How To Determine Your Rate

1. Select the plan below that best meets your needs (see Plan Details for a description of Optional Plan Features).

- Basic Plan
- Basic Plan plus Shortened Benefit Period
- Basic Plan plus Automatic Inflation
- Basic Plan plus Automatic Inflation & Shortened Benefit Period

2. Select the Daily Maximum Option that best meets your needs.

	Nursing Home Care Daily Max	Home & Comm.-Based Care Daily Max	Lifetime Maximum
Plan 1	$85	$43	$93,075
Plan 2	$85	$43	$186,150
Plan 3	$100	$50	$109,500
Plan 4	$100	$50	$219,000
Plan 5	$150	$75	$164,250
Plan 6	$150	$75	$328,500
Plan 7	$200	$100	$219,000
Plan 8	$200	$100	$438,000

3. Locate your age on the rate sheet and read across to your selected plan [from Step 1]. Then locate your selected Daily Maximum Option within that plan [from Step 2].

4. If you elect the Shortened Benefit Period Option, your rate [from Step 3] will be adjusted +19%.

5. The total annual premium payable may vary based on the frequency of premium payment and the method of payment (payroll deduction, direct billing, EFT). To calculate the total annual premium cost of each of the options available to you, multiply your monthly premium rate (from Step 3) by the appropriate factor from the table below:

Payment Mode	Annual Cost Factor
Direct Bill Annual	11.33
Direct Bill Semi-Annual	11.66
All Other Modes	12.00

EXAMPLE
If you select the Basic Plan, 3 Year Lifetime Maximum, Plan1, and if you are 30 years old, your monthly premium rate is **$6.83**.

If you elect to make two premium payments per year (semi-annual premium payments), your annual premium cost would be $6.83 x 11.66 = **$79.64**.

If your spouse selects the Basic Plan plus Shortened Benefit Period Option, 6 Year Lifetime Maximum, Plan 4, and if he/she is 30 years old, his/her monthly premium rate will be **$12.23**.

If you would prefer to have a Prudential Customer Service operator assist you with these calculations, you may call 1-800-732-0416.

Monthly Long Term Care Insurance Premium Rates
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	Basic Plan				Basic Plan plus Shortened Benefit Period Option				Basic Plan plus Automatic Inflation				Basic Plan Plus Automatic Inflation and Shortened Benefit Period Option			
	Plan 1	**Plan 3**	**Plan 5**	**Plan 7**	**Plan 1**	**Plan 3**	**Plan 5**	**Plan 7**	**Plan 1**	**Plan 3**	**Plan 5**	**Plan 7**	**Plan 1**	**Plan 3**	**Plan 5**	**Plan 7**
Age	**$85**	**$100**	**$150**	**$200**	**$85**	**$100**	**$150**	**$200**	**$85**	**$100**	**$150**	**$200**	**$85**	**$100**	**$150**	**$200**
18-30	6.83	8.03	12.05	16.06	8.13	9.56	14.34	19.11	25.68	30.21	45.32	60.42	30.56	35.95	53.93	71.90
31	7.18	8.45	12.68	16.90	8.54	10.06	15.09	20.11	26.85	31.59	47.39	63.18	31.95	37.59	56.39	75.18
32	7.54	8.87	13.31	17.74	8.97	10.56	15.84	21.11	28.11	33.07	49.61	66.14	33.45	39.35	59.04	78.71
33	7.91	9.30	13.95	18.60	9.41	11.07	16.60	22.13	29.37	34.55	51.83	69.10	34.95	41.11	61.68	82.23
34	8.35	9.82	14.73	19.64	9.94	11.69	17.53	23.37	30.62	36.02	54.03	72.04	36.44	42.86	64.30	85.73
35	8.80	10.35	15.53	20.70	10.47	12.32	18.48	24.63	31.97	37.61	56.42	75.22	38.04	44.76	67.14	89.51
36	9.16	10.78	16.17	21.56	10.90	12.83	19.24	25.66	33.41	39.30	58.95	78.60	39.76	46.77	70.15	93.53
37	9.70	11.41	17.12	22.82	11.54	13.58	20.37	27.16	34.93	41.09	61.64	82.18	41.57	48.90	73.35	97.79
38	10.15	11.94	17.91	23.88	12.08	14.21	21.31	28.42	36.55	43.00	64.50	86.00	43.49	51.17	76.76	102.34
39	10.68	12.57	18.86	25.14	12.71	14.96	22.44	29.92	38.17	44.90	67.35	89.80	45.42	53.43	80.15	106.86
40	11.23	13.21	19.82	26.42	13.36	15.72	23.59	31.44	39.87	46.91	70.37	93.82	47.45	55.82	83.74	111.65
41	11.85	13.94	20.91	27.88	14.10	16.59	24.88	33.18	41.75	49.12	73.68	98.24	49.68	58.45	87.68	116.91
42	12.57	14.79	22.19	29.58	14.96	17.60	26.41	35.20	43.73	51.45	77.18	102.90	52.04	61.23	91.84	122.45
43	13.29	15.64	23.46	31.28	15.82	18.61	27.92	37.22	45.80	53.88	80.82	107.76	54.50	64.12	96.18	128.23
44	14.01	16.48	24.72	32.96	16.67	19.61	29.42	39.22	47.95	56.41	84.62	112.82	57.06	67.13	100.70	134.26
45	14.82	17.43	26.15	34.86	17.64	20.74	31.12	41.48	50.19	59.05	88.58	118.10	59.73	70.27	105.41	140.54
46	15.72	18.49	27.74	36.98	18.71	22.00	33.01	44.01	52.62	61.91	92.87	123.82	62.62	73.67	110.52	147.35
47	16.61	19.54	29.31	39.08	19.77	23.25	34.88	46.51	55.05	64.76	97.14	129.52	65.51	77.06	115.60	154.13
48	17.60	20.71	31.07	41.42	20.94	24.64	36.97	49.29	57.65	67.82	101.73	135.64	68.60	80.71	121.06	161.41
49	18.59	21.87	32.81	43.74	22.12	26.03	39.04	52.05	60.44	71.10	106.65	142.20	71.92	84.61	126.91	169.22
50	19.67	23.14	34.71	46.28	23.41	27.54	41.30	55.07	63.31	74.48	111.72	148.96	75.34	88.63	132.95	177.26
51	21.23	24.98	37.47	49.96	25.26	29.73	44.59	59.45	66.94	78.75	118.13	157.50	79.66	93.71	140.57	187.43
52	22.98	27.04	40.56	54.08	27.35	32.18	48.27	64.36	70.76	83.25	124.88	166.50	84.20	99.07	148.61	198.14
53	24.84	29.22	43.83	58.44	29.56	34.77	52.16	69.54	74.79	87.99	131.99	175.98	89.00	104.71	157.07	209.42
54	26.88	31.62	47.43	63.24	31.99	37.63	56.44	75.26	79.09	93.05	139.58	186.10	94.12	110.73	166.10	221.46
55	29.02	34.14	51.21	68.28	34.53	40.63	60.94	81.25	83.69	98.46	147.69	196.92	99.59	117.17	175.75	234.33
56	31.34	36.87	55.31	73.74	37.29	43.88	65.82	87.75	88.49	104.10	156.15	208.20	105.30	123.88	185.82	247.76
57	33.95	39.94	59.91	79.88	40.40	47.53	71.29	95.06	93.58	110.09	165.14	220.18	111.36	131.01	196.52	262.01
58	36.66	43.13	64.70	86.26	43.63	51.32	76.99	102.65	98.96	116.42	174.63	232.84	117.76	138.54	207.81	277.08
59	39.66	46.66	69.99	93.32	47.20	55.53	83.29	111.05	104.63	123.09	184.64	246.18	124.51	146.48	219.72	292.95
60	42.85	50.41	75.62	100.82	50.99	59.99	89.99	119.98	110.59	130.11	195.17	260.22	131.60	154.83	232.25	309.66
61	46.51	54.72	82.08	109.44	55.35	65.12	97.68	130.23	114.62	134.85	202.28	269.70	136.40	160.47	240.71	320.94
62	50.45	59.35	89.03	118.70	60.04	70.63	105.95	141.25	118.84	139.81	209.72	279.62	141.42	166.37	249.57	332.75
63	53.76	63.25	94.88	126.50	63.97	75.27	112.91	150.54	121.13	142.50	213.75	285.00	144.14	169.58	254.36	339.15
64	57.45	67.59	101.39	135.18	68.37	80.43	120.65	160.86	123.61	145.42	218.13	290.84	147.10	173.05	259.57	346.10
65	64.54	75.93	113.90	151.86	76.80	90.36	135.54	180.71	132.29	155.64	233.46	311.28	157.43	185.21	277.82	370.42
66	70.04	82.40	123.60	164.80	83.35	98.06	147.08	196.11	139.99	164.69	247.04	329.38	166.59	195.98	293.98	391.96
67	75.99	89.40	134.10	178.80	90.43	106.39	159.58	212.77	148.22	174.38	261.57	348.76	176.38	207.51	311.27	415.02
68	82.49	97.05	145.58	194.10	98.16	115.49	173.24	230.98	156.83	184.50	276.75	369.00	186.63	219.56	329.33	439.11
69	89.45	105.23	157.85	210.46	106.45	125.22	187.84	250.45	166.07	195.38	293.07	390.76	197.62	232.50	348.75	465.00
70	97.04	114.17	171.26	228.34	115.48	135.86	203.80	271.72	175.78	206.80	310.20	413.60	209.18	246.09	369.14	492.18
71	107.75	126.77	190.16	253.54	128.22	150.86	226.29	301.71	189.98	223.50	335.25	447.00	226.08	265.97	398.95	531.93
72	119.48	140.56	210.84	281.12	142.18	167.27	250.90	334.53	205.26	241.48	362.22	482.96	244.26	287.36	431.04	574.72
73	132.57	155.96	233.94	311.92	157.76	185.59	278.39	371.18	221.83	260.98	391.47	521.96	263.98	310.57	465.85	621.13
74	147.13	173.09	259.64	346.18	175.08	205.98	308.97	411.95	239.68	281.98	422.97	563.96	285.22	335.56	503.33	671.11
75	163.23	192.04	288.06	384.08	194.24	228.53	342.79	457.06	259.09	304.81	457.22	609.62	308.32	362.72	544.09	725.45
76	181.46	213.48	320.22	426.96	215.94	254.04	381.06	508.08	281.89	331.63	497.45	663.26	335.45	394.64	591.97	789.28
77	201.78	237.39	356.09	474.78	240.12	282.49	423.75	564.99	306.79	360.93	541.40	721.86	365.08	429.51	644.27	859.01
78	224.31	263.89	395.84	527.78	266.93	314.03	471.05	628.06	333.80	392.70	589.05	785.40	397.22	467.31	700.97	934.63
79	249.39	293.40	440.10	586.80	296.77	349.15	523.72	698.29	363.19	427.28	640.92	854.56	432.20	508.46	762.69	1,016.93
80	277.22	326.14	489.21	652.28	329.89	388.11	582.16	776.21	395.23	464.98	697.47	929.96	470.32	553.33	829.99	1,106.65
81	298.83	351.56	527.34	703.12	355.61	418.36	627.53	836.71	419.86	493.95	740.93	987.90	499.63	587.80	881.71	1,175.60
82	322.08	378.92	568.38	757.84	383.28	450.91	676.37	901.83	446.05	524.76	787.14	1,049.52	530.80	624.46	936.70	1,248.93
83	347.07	408.32	612.48	816.64	413.01	485.90	728.85	971.80	473.88	557.50	836.25	1,115.00	563.92	663.43	995.14	1,326.85
84	374.17	440.20	660.30	880.40	445.26	523.84	785.76	1,047.68	503.45	592.29	888.44	1,184.58	599.11	704.83	1,057.24	1,409.65

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	Basic Plan				Basic Plan plus Shortened Benefit Period Option				Basic Plan plus Automatic Inflation				Basic Plan Plus Automatic Inflation and Shortened Benefit Period Option			
	Plan 2	**Plan 4**	**Plan 6**	**Plan 8**	**Plan 2**	**Plan 4**	**Plan 6**	**Plan 8**	**Plan 2**	**Plan 4**	**Plan 6**	**Plan 8**	**Plan 2**	**Plan 4**	**Plan 6**	**Plan 8**
Age	**$85**	**$100**	**$150**	**$200**	**$85**	**$100**	**$150**	**$200**	**$85**	**$100**	**$150**	**$200**	**$85**	**$100**	**$150**	**$200**
18-30	8.74	10.28	15.42	20.56	10.40	12.23	18.35	24.47	32.90	38.70	58.05	77.40	39.15	46.05	69.08	92.11
31	9.20	10.82	16.23	21.64	10.95	12.88	19.31	25.75	34.39	40.46	60.69	80.92	40.92	48.15	72.22	96.29
32	9.66	11.37	17.06	22.74	11.50	13.53	20.30	27.06	36.00	42.35	63.53	84.70	42.84	50.40	75.60	100.79
33	10.12	11.91	17.87	23.82	12.04	14.17	21.27	28.35	37.60	44.24	66.36	88.48	44.74	52.65	78.97	105.29
34	10.69	12.58	18.87	25.16	12.72	14.97	22.46	29.94	39.22	46.14	69.21	92.28	46.67	54.91	82.36	109.81
35	11.27	13.26	19.89	26.52	13.41	15.78	23.67	31.56	40.94	48.17	72.26	96.34	48.72	57.32	85.99	114.64
36	11.73	13.80	20.70	27.60	13.96	16.42	24.63	32.84	42.78	50.33	75.50	100.66	50.91	59.89	89.85	119.79
37	12.42	14.61	21.92	29.22	14.78	17.39	26.08	34.77	44.74	52.63	78.95	105.26	53.24	62.63	93.95	125.26
38	13.00	15.29	22.94	30.58	15.47	18.20	27.30	36.39	46.81	55.07	82.61	110.14	55.70	65.53	98.31	131.07
39	13.69	16.10	24.15	32.20	16.29	19.16	28.74	38.32	48.88	57.50	86.25	115.00	58.17	68.43	102.64	136.85
40	14.37	16.91	25.37	33.82	17.10	20.12	30.19	40.25	51.07	60.08	90.12	120.16	60.77	71.50	107.24	142.99
41	15.18	17.86	26.79	35.72	18.06	21.25	31.88	42.51	53.48	62.92	94.38	125.84	63.64	74.87	112.31	149.75
42	16.10	18.94	28.41	37.88	19.16	22.54	33.81	45.08	56.01	65.89	98.84	131.78	66.65	78.41	117.62	156.82
43	17.03	20.03	30.05	40.06	20.27	23.84	35.76	47.67	58.66	69.01	103.52	138.02	69.81	82.12	123.19	164.24
44	17.94	21.11	31.67	42.22	21.35	25.12	37.69	50.24	61.41	72.25	108.38	144.50	73.08	85.98	128.97	171.96
45	18.98	22.33	33.50	44.66	22.59	26.57	39.87	53.15	64.29	75.64	113.46	151.28	76.51	90.01	135.02	180.02
46	20.13	23.68	35.52	47.36	23.95	28.18	42.27	56.36	67.40	79.29	118.94	158.58	80.21	94.36	141.54	188.71
47	21.28	25.03	37.55	50.06	25.32	29.79	44.68	59.57	70.50	82.94	124.41	165.88	83.90	98.70	148.05	197.40
48	22.54	26.52	39.78	53.04	26.82	31.56	47.34	63.12	73.84	86.87	130.31	173.74	87.87	103.38	155.07	206.75
49	23.81	28.01	42.02	56.02	28.33	33.33	50.00	66.66	77.40	91.06	136.59	182.12	92.11	108.36	162.54	216.72
50	25.19	29.63	44.45	59.26	29.98	35.26	52.90	70.52	81.08	95.39	143.09	190.78	96.49	113.51	170.28	227.03
51	27.19	31.99	47.99	63.98	32.36	38.07	57.11	76.14	85.72	100.85	151.28	201.70	102.01	120.01	180.02	240.02
52	29.44	34.63	51.95	69.26	35.03	41.21	61.82	82.42	90.62	106.61	159.92	213.22	107.84	126.87	190.30	253.73
53	31.81	37.42	56.13	74.84	37.85	44.53	66.79	89.06	95.76	112.66	168.99	225.32	113.95	134.07	201.10	268.13
54	34.41	40.48	60.72	80.96	40.95	48.17	72.26	96.34	101.27	119.14	178.71	238.28	120.51	141.78	212.66	283.55
55	37.15	43.70	65.55	87.40	44.21	52.00	78.00	104.01	107.14	126.05	189.08	252.10	127.50	150.00	225.01	300.00
56	40.12	47.20	70.80	94.40	47.74	56.17	84.25	112.34	113.27	133.26	199.89	266.52	134.79	158.58	237.87	317.16
57	43.46	51.13	76.70	102.26	51.72	60.84	91.27	121.69	119.77	140.90	211.35	281.80	142.53	167.67	251.51	335.34
58	46.92	55.20	82.80	110.40	55.83	65.69	98.53	131.38	126.64	148.99	223.49	297.98	150.70	177.30	265.95	354.60
59	50.75	59.71	89.57	119.42	60.39	71.05	106.59	142.11	133.89	157.52	236.28	315.04	159.33	187.45	281.17	374.90
60	54.83	64.50	96.75	129.00	65.25	76.76	115.13	153.51	141.52	166.49	249.74	332.98	168.41	198.12	297.19	396.25
61	59.51	70.01	105.02	140.02	70.82	83.31	124.97	166.62	146.67	172.55	258.83	345.10	174.54	205.33	308.01	410.67
62	64.55	75.94	113.91	151.88	76.81	90.37	135.55	180.74	152.06	178.89	268.34	357.78	180.95	212.88	319.32	425.76
63	68.79	80.93	121.40	161.86	81.86	96.31	144.47	192.61	154.99	182.34	273.51	364.68	184.44	216.98	325.48	433.97
64	73.51	86.48	129.72	172.96	87.48	102.91	154.37	205.82	158.16	186.07	279.11	372.14	188.21	221.42	332.14	442.85
65	82.59	97.16	145.74	194.32	98.28	115.62	173.43	231.24	169.28	199.15	298.73	398.30	201.44	236.99	355.49	473.98
66	89.62	105.43	158.15	210.86	106.65	125.46	188.20	250.92	179.12	210.73	316.10	421.46	213.15	250.77	376.16	501.54
67	97.23	114.39	171.59	228.78	115.70	136.12	204.19	272.25	189.66	223.13	334.70	446.26	225.70	265.52	398.29	531.05
68	105.55	124.18	186.27	248.36	125.60	147.77	221.66	295.55	200.68	236.09	354.14	472.18	238.81	280.95	421.43	561.89
69	114.45	134.65	201.98	269.30	136.20	160.23	240.36	320.47	212.51	250.01	375.02	500.02	252.89	297.51	446.27	595.02
70	124.18	146.09	219.14	292.18	147.77	173.85	260.78	347.69	224.93	264.62	396.93	529.24	267.67	314.90	472.35	629.80
71	137.89	162.22	243.33	324.44	164.09	193.04	289.56	386.08	243.08	285.98	428.97	571.96	289.27	340.32	510.47	680.63
72	152.88	179.86	269.79	359.72	181.93	214.03	321.05	428.07	262.65	309.00	463.50	618.00	312.55	367.71	551.57	735.42
73	169.63	199.57	299.36	399.14	201.86	237.49	356.24	474.98	283.85	333.94	500.91	667.88	337.78	397.39	596.08	794.78
74	188.26	221.48	332.22	442.96	224.03	263.56	395.34	527.12	306.70	360.82	541.23	721.64	364.97	429.38	644.06	858.75
75	208.88	245.74	368.61	491.48	248.57	292.43	438.65	584.86	331.53	390.04	585.06	780.08	394.52	464.15	696.22	928.30
76	232.19	273.16	409.74	546.32	276.31	325.06	487.59	650.12	360.70	424.35	636.53	848.70	429.23	504.98	757.47	1,009.95
77	258.20	303.76	455.64	607.52	307.26	361.47	542.21	722.95	392.56	461.84	692.76	923.68	467.15	549.59	824.38	1,099.18
78	287.01	337.66	506.49	675.32	341.54	401.82	602.72	803.63	427.13	502.50	753.75	1,005.00	508.28	597.98	896.96	1,195.95
79	319.12	375.43	563.15	750.86	379.75	446.76	670.15	893.52	464.73	546.74	820.11	1,093.48	553.03	650.62	975.93	1,301.24
80	354.72	417.32	625.98	834.64	422.12	496.61	744.92	993.22	505.73	594.98	892.47	1,189.96	601.82	708.03	1,062.04	1,416.05
81	382.37	449.85	674.78	899.70	455.02	535.32	802.99	1,070.64	537.24	632.05	948.08	1,264.10	639.32	752.14	1,128.22	1,504.28
82	412.13	484.86	727.29	969.72	490.43	576.98	865.48	1,153.97	570.75	671.47	1,007.21	1,342.94	679.19	799.05	1,198.58	1,598.10
83	444.11	522.48	783.72	1,044.96	528.49	621.75	932.63	1,243.50	606.36	713.37	1,070.06	1,426.74	721.57	848.91	1,273.37	1,697.82
84	478.79	563.28	844.92	1,126.56	569.76	670.30	1,005.45	1,340.61	644.20	757.88	1,136.82	1,515.76	766.60	901.88	1,352.82	1,803.75

The Prudential Insurance Company of America
Prudential Long Term Care Customer Service Center
P.O. Box 8526, Philadelphia, PA 19176-8526 • 1-800-732-0416

Privacy Notice

IMPORTANT NOTICE ABOUT PRUDENTIAL'S INFORMATION PRACTICES

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Collecting Information for Underwriting

Prudential will review information about you to decide if you are eligible for coverage. In addition to your application/enrollment form, Prudential may obtain information about you from the following sources: a medical examination which we may ask you to take; an in-person health interview; the Medical Information Bureau (MIB); and doctors, hospitals or health care providers who have information about you or your mental or physical health.

Disclosing Information

We will treat any information we obtain or have obtained about you as confidential. However, we may disclose it to: your doctor, if we find a serious health problem you do not know about; the MIB; anyone conducting mortality or morbidity studies; and Company affiliates for insurance marketing, underwriting, policyholder service or claims handling. We may also disclose information to Company affiliates for non-insurance marketing purposes unless you write to us at our Long Term Care Customer Service Center and direct us not to make such a disclosure.* The Company or its reinsurers may make a brief report to the MIB, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, upon request, will supply such company with the information in its file. Similarly, the Company or its reinsurers may release information in its file to other life insurance companies to which you may apply for life or health insurance or to which a claim for benefits may be submitted.

Your Right to Information

If we do not issue the policy you requested, we will tell you and explain the reasons for our decision. If you write to us, we will describe the information we have relating to this insurance transaction, describe how you may access it, and tell you how you may request correction, amendment or deletion of information that you dispute. Please note that requested information from your medical records will only be released to a medical professional designated by you.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the MIB's file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

**This sentence does not apply to residents of Minnesota.*

State Notices

IMPORTANT STATE NOTICES ABOUT PRUDENTIAL LONG TERM CARE℠ INSURANCE

Caution: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, may commit a fraudulent insurance act, which is a crime that may subject such person to criminal and/or civil penalties.

To residents of California:
THIS PLAN IS APPROVED LONG-TERM CARE INSURANCE UNDER CALIFORNIA LAW AND REGULATIONS. HOWEVER, THE BENEFITS PAYABLE BY THIS INSURANCE WILL NOT QUALIFY FOR MEDI-CAL ASSET PROTECTION UNDER THE CALIFORNIA PARTNERSHIP FOR LONG-TERM CARE. FOR INFORMATION ABOUT INSURANCE UNDER THE CALIFORNIA PARTNERSHIP FOR LONG TERM CARE, CALL THE HEALTH INSURANCE COUNSELING AND ADVOCACY PROGRAM (HICAP) AT THIS TOLL-FREE NUMBER: 1-800-434-0222.

To residents of Illinois:
The policy is not approved for Medicaid Asset Protection under the Illinois Long Term Care Partnership Program. However, the policy is an approved long term care policy under state insurance regulations. For information about policies approved under the Illinois Long Term Care Partnership Program, call the Senior Helpline at the Illinois Department on Aging at 1-800-252-8966.

To residents of Iowa:
The policy does not qualify for Medicaid Asset Protection under the Iowa Long Term Care Asset Preservation Program. However, the policy is an approved long term care policy under state insurance regulations. For information about policies and certificates qualifying under the Iowa Long Term Care Asset Preservation Program, call the Senior Health Insurance Information Program of the Iowa Division of Insurance at 1-800-281-5705.

To residents of Massachusetts:
FEDERAL INCOME TAX EXEMPTIONS: This Coverage IS intended to be a federally qualified long-term care insurance contract under section 7702B(b) of the Internal Revenue Code of 1986, as amended.

STATE MASSHEALTH (MEDICAID) EXEMPTIONS: This Coverage IS intended to satisfy Massachusetts' minimum long-term care insurance coverage requirements as of the Certificate's Effective Date for certain asset and liability exemptions under the Massachusetts MassHealth (Medicaid) Program if you purchase a Plan with a Nursing Home Daily Maximum greater than $125 per day. Please note that there may be other MassHealth (Medicaid) requirements to qualify for these exemptions. Although this Certificate may satisfy requirements at the time it is issued, it may not qualify at the time you enter a nursing home if you have used benefits.

To residents of New Jersey: Caution: Any person who includes any false or misleading information on an application for coverage under a group policy is subject to criminal and civil penalties.

To residents of New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

The Prudential Insurance Company of America
Prudential Long Term Care Customer Service Center
P.O. Box 8526, Philadelphia, PA 19176-8526 • 1-800-732-0416

Enrollment Form

INSTRUCTIONS: Read and complete all necessary parts of this enrollment form. **Please print using blue or black ink.** Use an "X" to mark boxes where indicated. **Provide your signature in all areas required**. Return completed forms to: Prudential Long Term Care Unit, P.O. Box 8526, Philadelphia, PA 19176-8526. *If you have questions, call 1-800-732-0416.*

A APPLICANT INFORMATION

Eligibility Status
(check one)
☐ Actively-at-work Full-time Employee
☐ Actively-at-work Part-time Employee (20 or more hours/wk)
☐ Actively-at-work Contract or Part-time Employee (under 20 hours/wk)
☐ Retiree
☐ Spouse
☐ Parent
☐ Parent-in-law
☐ Grandparent
☐ Grandparent-in-law
☐ Adult Child
☐ Spouse of Adult Child
☐ Siblings

☐ Mr. ☐ Mrs. ☐ Ms. ☐ ____ **Marital Status** ☐ Married ☐ Unmarried

Full name

Address **Apt.**
No P.O. Boxes please

City **State** **ZIP**

Daytime phone ( ) - **Evening phone** ( ) -
Best time to call: ☐ AM ☐ PM

Date of birth **Date of hire** **Social Security number**

If married, is your spouse applying for this insurance? **Yes** ☐ **No** ☐

If your spouse currently has Prudential Long Term Care℠ Insurance, please provide policy/certificate number:

Agency code* Payroll code* ☐ R – Regular ☐ S – Satellite ☐ U – University

Benefit Coordinator name Phone number ( ) -

*Please see attached reference sheet.

If this application is for someone other than an eligible employee (e.g., a spouse, family member, or other relation), please provide information about the eligible employee in this section.

Employee full name Date of hire

Employee Social Security number

Daytime phone ( ) - Evening phone ( ) -

B BENEFIT OPTIONS SELECTION for Federally Tax Qualified Long Term Care Insurance contract

1. Coverage Amounts	Nursing Home Care & Assisted Living Facility Daily Maximum	Home & Community-Based Care Daily Maximum	Lifetime Maximum
☐ Plan 1	$85	$43	$93,075
☐ Plan 2	$85	$43	$186,150
☐ Plan 3	$100	$50	$109,500
☐ Plan 4	$100	$50	$219,000
☐ Plan 5	$150	$75	$164,250
☐ Plan 6	$150	$75	$328,500
☐ Plan 7	$200	$100	$219,000
☐ Plan 8	$200	$100	$438,000

Prudential Financial

2. Optional Automatic Inflation Increase Rider — I have reviewed the Outline of Coverage and the graphs which compare the benefits and premiums of this Coverage with and without this Rider, and I want this Rider included in my Coverage. **Yes** ☐ **No** ☐

If you choose "NO" for the Automatic Inflation Increase Rider, please sign below.
I reject inflation protection.

X Applicant Signature _____ Date _____

3. Optional Non-Forfeiture Benefit Rider — I have reviewed the explanation of the optional Non-Forfeiture Benefit in the Outline of Coverage, and I want this Rider included in my Coverage. **Yes** ☐ **No** ☐

C PAYMENT METHOD

Permanent Employees and their Spouse may elect Payroll Deduction. Contract Employees, Part-time Employees (working less than 20 hours per week) and all Qualified Family Members must elect Direct Billing or Electronic Funds Transfer (EFT).

Choose ONE of the following payment plans.

☐ **Payroll Deduction** If choosing this option, indicate your current payroll frequency:
☐ Bi-Weekly ☐ Monthly

☐ **Electronic Funds Transfer (EFT) — Monthly Payment** If choosing this option, you must complete and return the enclosed EFT Authorization Form and a sample voided check.

☐ **Direct Billing**

Bill to:
☐ Applicant
☐ Employee, if other than applicant

How often:
☐ Quarterly
☐ Semi-Annually
☐ Annually

Billing address, if different from Section A:
_____
_____

D INSURANCE HISTORY

1. Are you covered by Medicaid or Medi-Cal (not Medicare)? **Yes** ☐ **No** ☐

2. Do you have another long term care insurance policy or certificate in force (including health care service contract or health maintenance organization contract)? **Yes** ☐ **No** ☐

3. Did you have another long term care insurance policy or certificate in force during the last 12 months? **Yes** ☐ **No** ☐

4. Do you intend to replace any of your medical or health insurance coverage with this insurance? **Yes** ☐ **No** ☐

If you answered "YES" to questions 3 or 4 of this section, please provide the following information.

Name of company _____
Address _____
_____
Policy number _____
Check type: ☐ Group ☐ Individual
Amount of Coverage: $ _____
☐ Check here if you intend to replace this policy.
☐ Check here if this policy lapsed. Give date: _____

Name of company _____
Address _____
_____
Policy number _____
Check type: ☐ Group ☐ Individual
Amount of Coverage: $ _____
☐ Check here if you intend to replace this policy.
☐ Check here if this policy lapsed. Give date: _____

E NOTIFICATION OF UNINTENTIONAL LAPSE

You can provide Prudential with the name of a friend or relative to notify if your coverage is about to lapse because the premium was not paid when due. This designation does not constitute an acceptance of liability by the person named. Prudential will notify you each year of your right to designate or change the existing designation for this purpose. **Choose ONE of the following options:**

☐ **Name a Designee**

First name M.I.

Last name

Address

City

State ZIP

☐ **Waive this Notice option**

I understand that I have the right to name at least one person other than myself to receive notice of lapse or termination of my long term care insurance coverage for non-payment of premium. I understand that notice will not be given until 30 days after the premium is due and not paid. **By my signature, I elect NOT to name any person to receive such notice.**

X Applicant's signature

Date

F APPLICANT AGREEMENTS

Caution: If your answers on this Enrollment Form are misstated or untrue, Prudential may have the right to deny benefits or rescind your coverage.

To the best of my knowledge and belief, the answers on this Enrollment Form are complete and true. I understand and agree that:

1. The Long Term Care Insurance coverage is underwritten by The Prudential Insurance Company of America (Prudential), whose corporate offices are located in Newark, New Jersey.
2. This Enrollment Form will be the basis for the Long Term Care Insurance coverage for which I am applying to Prudential under a Group Contract.
3. My coverage will NOT take effect unless Prudential has approved this Enrollment Form. If issued, my Long Term Care Insurance coverage will take effect on the Effective Date assigned by Prudential.
4. Prudential has the right to change premium rates in the future but only on a class basis.
5. If Payroll Deduction is indicated in Section C, I authorize State of Maryland to make the payroll deductions needed for premium payment for the applicant listed in Section A. I understand all deductions for this applicant and other applicants for whom I am authorizing deductions will appear as one line item on my payroll/earnings statement.
6. I have received the Outline of Coverage and *A Shopper's Guide to Long Term Care Insurance.*
7. I have received the Privacy Notice concerning Prudential's Information Practices.
8. If I am eligible for Medicare, I have received the *Guide to Health Insurance for People with Medicare.*
9. I have read, or had read to me, the completed Enrollment Form, and I understand that any false statement or misrepresentation in my Enrollment Form may result in loss of coverage under the Group Contract.
10. Benefits and the costs of each of the options have been fully explained to me.

X Applicant's signature Date

NOTE: If Payroll Deduction is selected in Section C, and if this application is for someone other than an eligible employee, please be sure that the employee authorizes payroll deduction by signing below.

X Employee's signature (if other than applicant) Date

Prudential Financial

Instructions

IF YOU ARE:

An actively-at-work full-time or part-time State of Maryland/Satellite Account employee (working at least 20 hours per week), and enrolling **more than** 60 days following your date of hire

-or-

A retiree

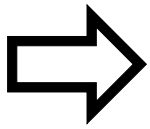
-or-

An eligible employee or retiree's family member (spouse, parent, parent-in-law, grandparent, grandparent-in-law, adult child or their spouse, or a sibling)

-or-

A contract or part-time employees (working less than 20 hours/week)

USE THIS FORM



- Please sign the Authorization for Release of Health-Related Information
- Please return all forms to Prudential using the enclosed business reply envelope.

The Prudential Insurance Company of America
Prudential Long Term Care Customer Service Center
P.O. Box 8526, Philadelphia, PA 19176-8526 • 1-800-732-0416

Eligibility

WHO CAN ENROLL FOR THIS COVERAGE?

The following persons can enroll for the Prudential Long Term Care℠ Insurance Plan sponsored by State of Maryland:

1) An Actively-at-work Full-time or Part-time State of Maryland/Satellite Account Employee and State Retirees; or
2) Persons who are related to an Employee or Retiree in one of the following ways:
   a) Their Spouse
   b) Their Parent or grandparent (including in-laws)
   c) The Spouse of the parent or grandparent
   d) Their Adult child or the adult child's spouse
   e) Siblings.

You must be at least age 18 but less than age 85 when your Enrollment Form is completed.

Contract Employees, Part-time Employees (working less than 20 hours per week), Retired Employees and all Qualified Family Members are required to provide evidence of insurability as part of the enrollment process. All sections of the Enrollment Form must be completed.

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Disclosing Information

We will treat any information we obtain or have obtained about you as confidential. However, we may disclose it to: your doctor, if we find a serious health problem you do not know about; the MIB; anyone conducting mortality or morbidity studies; and Company affiliates for insurance marketing, underwriting, policyholder service or claims handling. We may also disclose information to Company affiliates for non-insurance marketing purposes unless you write to us at our Long Term Care Customer Service Center and direct us not to make such a disclosure.* The Company or its reinsurers may make a brief report to the MIB, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, upon request, will supply such company with the information in its file. Similarly, the Company or its reinsurers may release information in its file to other life insurance companies to which you may apply for life or health insurance or to which a claim for benefits may be submitted.

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To residents of Illinois:
The policy is not approved for Medicaid Asset Protection under the Illinois Long Term Care Partnership Program. However, the policy is an approved long term care policy under state insurance regulations. For information about policies approved under the Illinois Long Term Care Partnership Program, call the Senior Helpline at the Illinois Department on Aging at 1-800-252-8966.

To residents of Iowa:
The policy does not qualify for Medicaid Asset Protection under the Iowa Long Term Care Asset Preservation Program. However, the policy is an approved long term care policy under state insurance regulations. For information about policies and certificates qualifying under the Iowa Long Term Care Asset Preservation Program, call the Senior Health Insurance Information Program of the Iowa Division of Insurance at 1-800-281-5705.

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FEDERAL INCOME TAX EXEMPTIONS: This Coverage IS intended to be a federally qualified long-term care insurance contract under section 7702B(b) of the Internal Revenue Code of 1986, as amended.

STATE MASSHEALTH (MEDICAID) EXEMPTIONS: This Coverage IS intended to satisfy Massachusetts' minimum long-term care insurance coverage requirements as of the Certificate's Effective Date for certain asset and liability exemptions under the Massachusetts MassHealth (Medicaid) Program if you purchase a Plan with a Nursing Home Daily Maximum greater than $125 per day. Please note that there may be other MassHealth (Medicaid) requirements to qualify for these exemptions. Although this Certificate may satisfy requirements at the time it is issued, it may not qualify at the time you enter a nursing home if you have used benefits.

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Enrollment Form

INSTRUCTIONS: Read and complete all necessary parts of this enrollment form. **Please print using blue or black ink.** Use an "X" to mark boxes where indicated. **Provide your signature in all areas required**. Return completed forms to: Prudential Long Term Care Unit, P.O. Box 8526, Philadelphia, PA 19176-8526. *If you have questions, call 1-800-732-0416.*

A APPLICANT INFORMATION

Eligibility Status
(check one)
☐ Actively-at-work Full-time Employee
☐ Actively-at-work Part-time Employee (20 or more hours/wk)
☐ Actively-at-work Contract or Part-time Employee (under 20 hours/wk)
☐ Retiree
☐ Spouse
☐ Parent
☐ Parent-in-law
☐ Grandparent
☐ Grandparent-in-law
☐ Adult Child
☐ Spouse of Adult Child
☐ Siblings

☐ Mr. ☐ Mrs. ☐ Ms. ☐ ____ **Marital Status** ☐ Married ☐ Unmarried

Full name

Address **Apt.**
No P.O. Boxes please

City **State** **ZIP**

Daytime phone ( ) - **Evening phone** ( ) -
Best time to call: ☐ AM ☐ PM

Date of birth **Date of hire** **Social Security number**

If married, is your spouse applying for this insurance? **Yes** ☐ **No** ☐

If your spouse currently has Prudential Long Term Care℠ Insurance, please provide policy/certificate number:

Agency code* Payroll code* ☐ R – Regular ☐ S – Satellite ☐ U – University

Benefit Coordinator name Phone number ( ) -

*Please see attached reference sheet.

If this application is for someone other than an eligible employee (e.g., a spouse, family member, or other relation), please provide information about the eligible employee in this section.

Employee full name Date of hire

Employee Social Security number

Daytime phone ( ) - Evening phone ( ) -

B BENEFIT OPTIONS SELECTION for Federally Tax Qualified Long Term Care Insurance contract

1. Coverage Amounts	Nursing Home Care & Assisted Living Facility Daily Maximum	Home & Community-Based Care Daily Maximum	Lifetime Maximum
☐ Plan 1	$85	$43	$93,075
☐ Plan 2	$85	$43	$186,150
☐ Plan 3	$100	$50	$109,500
☐ Plan 4	$100	$50	$219,000
☐ Plan 5	$150	$75	$164,250
☐ Plan 6	$150	$75	$328,500
☐ Plan 7	$200	$100	$219,000
☐ Plan 8	$200	$100	$438,000

Prudential Financial

2. Optional Automatic Inflation Increase Rider — I have reviewed the Outline of Coverage and the graphs which compare the benefits and premiums of this Coverage with and without this Rider, and I want this Rider included in my Coverage. **Yes** ☐ **No** ☐

If you choose "NO" for the Automatic Inflation Increase Rider, please sign below.
I reject inflation protection.

X Applicant Signature _____ Date _____

3. Optional Non-Forfeiture Benefit Rider — I have reviewed the explanation of the optional Non-Forfeiture Benefit in the Outline of Coverage, and I want this Rider included in my Coverage. **Yes** ☐ **No** ☐

C PAYMENT METHOD

Permanent Employees and their Spouse may elect Payroll Deduction. Contract Employees, Part-time Employees (working less than 20 hours per week) and all Qualified Family Members must elect Direct Billing or Electronic Funds Transfer (EFT).

Choose ONE of the following payment plans.

☐ **Payroll Deduction** If choosing this option, indicate your current payroll frequency:
☐ Bi-Weekly ☐ Monthly

☐ **Electronic Funds Transfer (EFT) — Monthly Payment** If choosing this option, you must complete and return the enclosed EFT Authorization Form and a sample voided check.

☐ **Direct Billing**

Bill to:
☐ Applicant
☐ Employee, if other than applicant

How often:
☐ Quarterly
☐ Semi-Annually
☐ Annually

Billing address, if different from Section A:
_____
_____

D INSURANCE HISTORY

1. Are you covered by Medicaid or Medi-Cal (not Medicare)? **Yes** ☐ **No** ☐

2. Do you have another long term care insurance policy or certificate in force (including health care service contract or health maintenance organization contract)? **Yes** ☐ **No** ☐

3. Did you have another long term care insurance policy or certificate in force during the last 12 months? **Yes** ☐ **No** ☐

4. Do you intend to replace any of your medical or health insurance coverage with this insurance? **Yes** ☐ **No** ☐

If you answered "YES" to questions 3 or 4 of this section, please provide the following information.

Name of company _____
Address _____
_____
Policy number _____
Check type: ☐ Group ☐ Individual
Amount of Coverage: $ _____
☐ Check here if you intend to replace this policy.
☐ Check here if this policy lapsed. Give date: _____

Name of company _____
Address _____
_____
Policy number _____
Check type: ☐ Group ☐ Individual
Amount of Coverage: $ _____
☐ Check here if you intend to replace this policy.
☐ Check here if this policy lapsed. Give date: _____

E NOTIFICATION OF UNINTENTIONAL LAPSE

You can provide Prudential with the name of a friend or relative to notify if your coverage is about to lapse because the premium was not paid when due. This designation does not constitute an acceptance of liability by the person named. Prudential will notify you each year of your right to designate or change the existing designation for this purpose. **Choose ONE of the following options:**

☐ **Name a Designee**

First name M.I.

Last name

Address

City

State ZIP

☐ **Waive this Notice option**

I understand that I have the right to name at least one person other than myself to receive notice of lapse or termination of my long term care insurance coverage for non-payment of premium. I understand that notice will not be given until 30 days after the premium is due and not paid. **By my signature, I elect NOT to name any person to receive such notice.**

X Applicant's signature

Date

F APPLICANT AGREEMENTS

Caution: If your answers on this Enrollment Form are misstated or untrue, Prudential may have the right to deny benefits or rescind your coverage.

To the best of my knowledge and belief, the answers on this Enrollment Form are complete and true. I understand and agree that:

1. The Long Term Care Insurance coverage is underwritten by The Prudential Insurance Company of America (Prudential), whose corporate offices are located in Newark, New Jersey.
2. This Enrollment Form will be the basis for the Long Term Care Insurance coverage for which I am applying to Prudential under a Group Contract.
3. My coverage will NOT take effect unless Prudential has approved this Enrollment Form. If issued, my Long Term Care Insurance coverage will take effect on the Effective Date assigned by Prudential.
4. Prudential has the right to change premium rates in the future but only on a class basis.
5. If Payroll Deduction is indicated in Section C, I authorize State of Maryland to make the payroll deductions needed for premium payment for the applicant listed in Section A. I understand all deductions for this applicant and other applicants for whom I am authorizing deductions will appear as one line item on my payroll/earnings statement.
6. I have received the Outline of Coverage and *A Shopper's Guide to Long Term Care Insurance.*
7. I have received the Privacy Notice concerning Prudential's Information Practices.
8. If I am eligible for Medicare, I have received the *Guide to Health Insurance for People with Medicare.*
9. I have read, or had read to me, the completed Enrollment Form, and I understand that any false statement or misrepresentation in my Enrollment Form may result in loss of coverage under the Group Contract.
10. Benefits and the costs of each of the options have been fully explained to me.

X Applicant's signature Date

NOTE: If Payroll Deduction is selected in Section C, and if this application is for someone other than an eligible employee, please be sure that the employee authorizes payroll deduction by signing below.

X Employee's signature (if other than applicant) Date

Prudential Financial

The Prudential Insurance Company of America
Prudential Long Term Care Customer Service Center
P.O. Box 8526, Philadelphia, PA 19176-8526 • 1-800-732-0416

Medical History & Insurability Form for Long Term Care Insurance

INSTRUCTIONS: Read and complete all necessary parts of this Medical History & Insurability Form. **Please print using blue or black ink.** Use an "X" to mark boxes where indicated. **Provide your signature in all areas required**. If you answer "NO" to each question, attach the completed Insurability Profile Form to your Enrollment Form and mail it in the enclosed, postage-paid envelope to: Prudential Long Term Care Unit, P.O. Box 8526, Philadelphia, PA 19176-8526. *If you have questions, call 1-800-732-0416.*

The following does not apply to residents of California, New Jersey, New York: Caution: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, may commit a fraudulent insurance act, which is a crime that may result in criminal and/or civil penalties.

To residents of California: Caution: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, may commit a fraudulent insurance act, which is a crime that may subject such person to criminal and/or civil penalties.

To residents of New Jersey: Caution: Any person who includes any false or misleading information on an application for coverage under a group policy is subject to criminal and civil penalties.

To residents of New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

A APPLICANT INFORMATION

Full name _____

Daytime phone ( ) - **Evening phone** ( ) - Best time to call: ☐ AM ☐ PM

Date on accompanying enrollment form **Group Contract Holder** State of Maryland

B TELL US ABOUT YOUR INSURABILITY

1. Within the past 7 years, have you had, do you currently have, or have you been diagnosed or treated by a Licensed Health Care Practitioner as having any of the following medical conditions:

Amyotrophic lateral sclerosis, multiple sclerosis, muscular dystrophy, or Parkinson's disease?	**Yes** ☐	**No** ☐
Alzheimer's disease, chronic memory loss, frequent or persistent forgetfulness, senility, dementia or organic brain syndrome?	**Yes** ☐	**No** ☐
Congestive heart failure, diagnosed or symptomatic, within the past 12 months?	**Yes** ☐	**No** ☐
Diabetes treated with insulin or liver cirrhosis?	**Yes** ☐	**No** ☐
Metastatic cancer (cancer that has spread from the original site or location)?	**Yes** ☐	**No** ☐
Stroke or cerebrovascular accident?	**Yes** ☐	**No** ☐
Transient Ischemic Attack (TIA) within the past 5 years, multiple TIAs, or TIA in combination with diabetes or any heart surgery?	**Yes** ☐	**No** ☐
2. Within the past 48 months, have you been diagnosed or treated for cancer of a major body organ?	**Yes** ☐	**No** ☐
3. Do you use any of the following: walker or quad-cane, wheelchair or motorized cart, oxygen, respirator, or kidney dialysis?	**Yes** ☐	**No** ☐

Prudential Financial

4. **Within the past 12 months, have you needed home health care/home care, used adult day care, or received care in a nursing home, assisted living/residential care facility or other long term care facility?** **Yes** ☐ **No** ☐

5. **Within the past 12 months, have you been medically advised to enter a nursing home, assisted living/residential care facility, or other long term care facility?** **Yes** ☐ **No** ☐

6. **Do you currently need assistance or supervision by another person for taking your medication or in performing any of the following Activities of Daily Living (ADLs):** bathing, eating, toileting, bowel or bladder control (continence), dressing, or moving in and out of bed or chair? **Yes** ☐ **No** ☐

7. **This section pertains to Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) and, if permitted, HIV-related (Human Immunodeficiency Virus) diagnosis and treatment. PLEASE COMPLETE THE SECTION BELOW THAT CORRESPONDS TO YOUR STATE OF RESIDENCE.**

ALL states except California, Florida, Maine, Maryland, New York or Wisconsin

Within the past 10 years, have you had, do you currently have, or have you been diagnosed or treated by a Licensed Health Care Practitioner, as having any of the following medical conditions:

Acquired Immune Deficiency Syndrome (AIDS)? **Yes** ☐ **No** ☐
AIDS Related Complex (ARC)? **Yes** ☐ **No** ☐
Any HIV infection (Human Immunodeficiency Virus)? **Yes** ☐ **No** ☐

Florida

Within the past 10 years, have you tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection? **Yes** ☐ **No** ☐

California, Maine, New York and Wisconsin

You may answer these questions "No" if you have tested positive for HIV (Human Immunodeficiency Virus) and have not developed symptoms of the disease AIDS. Within the past 10 years, have you had, do you currently have, or have you been diagnosed or treated by a Licensed Health Care Practitioner, as having any of the following medical conditions:

Acquired Immune Deficiency Syndrome (AIDS)? **Yes** ☐ **No** ☐
AIDS Related Complex (ARC)? **Yes** ☐ **No** ☐

Maryland

Within the past 7 years, have you had, do you currently have, or have you been diagnosed or treated by a Licensed Health Care Practitioner, as having any of the following medical conditions:

Acquired Immune Deficiency Syndrome (AIDS)? **Yes** ☐ **No** ☐
AIDS Related Complex (ARC)? **Yes** ☐ **No** ☐
Any HIV infection (Human Immunodeficiency Virus)? **Yes** ☐ **No** ☐

NOTE: If you answered "YES" to any question in Part B, do not complete the remainder of this form. We regret that we will be unable to offer you long term care coverage because you do not meet our minimum acceptance criteria. If you answered "NO" to all questions in Part B, please continue.

C TELL US ABOUT YOUR MEDICAL HISTORY

1. Height: ____ ft ____ in **Weight:** _____ lbs **Gender:** ☐ Male ☐ Female

2. List any activities in which you regularly participate outside your home (e.g., walking or gardening): _____

3. Have 2 or more years passed since you received ANY medical examination or treatment by a healthcare professional? **Yes** ☐ **No** ☐

4. Who is your Primary Care Physician with most of your medical records? (Please print neatly)

Name _____ Phone _____

Address _____

City _____ State _____ Zip _____

Reason for last visit _____ Date of last visit _____

5. Within the past 3 years, have you been advised by a Licensed Health Care Practitioner to have surgery that has not been performed? **Yes** ☐ **No** ☐

Condition _____ Date last treated _____

6. Check the appropriate boxes for any care received within the past 3 years:

Home health care	**Yes** ☐	**No** ☐
Adult day care	**Yes** ☐	**No** ☐
Nursing home, assisted living/residential care facility or other long term care facility	**Yes** ☐	**No** ☐

7. Within the past 5 years (7 years for cancer), have you received any advice or treatment from a Licensed Health Care Practitioner, taken any medications for, or been medically diagnosed for:

Any heart or circulatory conditions (angina, congestive heart failure, heart attack, heart surgery, irregular heart beat, numbness or peripheral vascular disease)?	**Yes** ☐	**No** ☐
Cancer of any kind, Hodgkin's disease, leukemia, or lymphoma?	**Yes** ☐	**No** ☐
Tumors (non-cancerous) or skin ulcers, amputation or paralysis?	**Yes** ☐	**No** ☐
Any breathing conditions, such as asthma, chronic bronchitis, chronic obstructive pulmonary disease, emphysema, shortness of breath or tuberculosis?	**Yes** ☐	**No** ☐
Cirrhosis, non-insulin dependent diabetes or hepatitis?	**Yes** ☐	**No** ☐
Brain disorder, black-outs, convulsions, epilepsy or seizures?	**Yes** ☐	**No** ☐
Anxiety, depression or other mental, emotional or nervous disorder?	**Yes** ☐	**No** ☐
Alcoholism or chemical dependency?	**Yes** ☐	**No** ☐
Bone or spinal disorders such as osteoarthritis or rheumatoid arthritis, osteoporosis or joint replacement?	**Yes** ☐	**No** ☐
High blood pressure, dizziness, or balance problems?	**Yes** ☐	**No** ☐

In the space below, provide details for any "YES" answers. If additional space is required, attach the details on a separate piece of paper, including your name and Social Security number. You must also sign and date that page.

Condition _____

Date last treated _____

Name, address and phone of the Licensed Health Care Practitioner who treated your condition:

Condition _____

Date last treated _____

Name, address and phone of the Licensed Health Care Practitioner who treated your condition:

8. Within the past 5 years, have you received any advice or treatment from a Licensed Health Care Practitioner other than your Primary Care Physician for any reason not stated? **Yes** ☐ **No** ☐
(For residents of California, Connecticut, Florida, Maine, New Jersey, New York, North Dakota, Vermont, and Wisconsin, this does not include HIV testing (Human Immunodeficiency Virus).)

If you answered "YES," please provide details below.

Condition ______________________

Date last treated ______________________ ☐ Check here if treated by your Primary Care Physician only.

Name, address and phone of any other Licensed Health Care Practitioner who treated your condition:

____

____

____

Condition ______________________

Date last treated ______________________ ☐ Check here if treated by your Primary Care Physician only.

Name, address and phone of any other Licensed Health Care Practitioner who treated your condition:

____

____

____

9. Are you currently taking any drug or medication? **Yes** ☐ **No** ☐

If you answered "YES," please provide details below.

Drug or medication ______________________

Dosage ______________________

How long have you been taking this medication?

____

☐ Check here if treated by Primary Care Physician only.

If prescribed by another Licensed Health Care Practitioner, give name, address and phone number, and the condition:

____

____

____

Drug or medication ______________________

Dosage ______________________

How long have you been taking this medication?

____

☐ Check here if treated by Primary Care Physician only.

If prescribed by another Licensed Health Care Practitioner, give name, address and phone number, and the condition:

____

____

____

Drug or medication ______________________

Dosage ______________________

How long have you been taking this medication?

____

☐ Check here if treated by Primary Care Physician only.

If prescribed by another Licensed Health Care Practitioner, give name, address and phone number, and the condition:

____

____

____

Drug or medication ______________________

Dosage ______________________

How long have you been taking this medication?

____

☐ Check here if treated by Primary Care Physician only.

If prescribed by another Licensed Health Care Practitioner, give name, address and phone number, and the condition:

____

____

____

D READ AND SIGN APPLICANT AGREEMENTS

Caution: If your answers on this form are incorrect or untrue, or fail to include all material medical information requested, Prudential may have the right to deny benefits or rescind your insurance coverage.

To the best of my knowledge and belief, the answers on this form are complete and true. I understand and agree:

- The information on this form is the basis for the coverage for which I am applying to The Prudential Insurance Company of America (Prudential).
- My coverage will NOT take effect unless: Prudential has approved this form and statements and answers given in applying for this coverage do not change materially until the date this form is approved.
- I have read this form or had this form read to me, and I understand that any false statement or misrepresentation in this form may result in loss of coverage under the Group Contract.

X Applicant signature _____ Date _____

The Prudential Insurance Company of America
Prudential Long Term Care Customer Service Center
P.O. Box 8526, Philadelphia, PA 19176-8526 • 1-800-732-0416

Health Insurance Portability and Accountability Act (HIPAA) Form

AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION
This authorization is intended to comply with the HIPAA Privacy Rule.

Please print.

Name of applicant _____

Date of birth _____ **Social Security number** _____

I authorize any health plan, doctor, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided treatment or services to me or on my behalf ("My Providers"), and any other medical or insurance organization, institution or professional, to disclose my entire medical record and any other health information concerning me, without restriction, to The Prudential Insurance Company of America and its agents, employees and representatives ("Prudential"). This includes medical records and information on diagnoses and/or treatment relating to Human Immunodeficiency Virus (HIV) infection or Acquired Immunodeficiency Syndrome (AIDS), sexually transmitted disease, mental illness, and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I terminate any agreements I have made with My Providers to restrict my protected health information and, for purposes of this authorization, I instruct My Providers to release and disclose my entire medical record without restriction to Prudential.

This information is to be disclosed under this authorization so that Prudential may do the following, with respect to long term care insurance I am applying for: underwrite or make rating determinations, evaluate and determine my eligibility for long term care insurance, or conduct other legally permissible activities related to my application.

This authorization shall remain in force for 24 months following the date of my signature below, unless state law imposes a shorter duration. A copy of this authorization is as valid as the original. I understand that I have the right to withdraw this authorization in writing, at any time, by sending a written request to: The Prudential Insurance Company of America, Long Term Care Customer Service Center, P.O. Box 8519, Philadelphia, PA 19176, ATTN: Privacy Contact. I understand that a withdrawal is not effective if any of My Providers has relied on this authorization or to the extent that Prudential has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be re-disclosed, to the extent allowable under federal law and no longer covered by certain federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization, Prudential may not be able to process my application or, if coverage has been issued, may not be able to make any benefit payments. I understand that Prudential will provide me with a copy of this authorization.

X Signature of applicant or personal representative _____ Date _____

Description of personal representative's authority or relationship to applicant _____

Detach and mail with your enrollment form.

Prudential Financial

The Prudential Insurance Company of America
Prudential Long Term Care Customer Service Center
P.O. Box 8526, Philadelphia, PA 19176-8526 • 1-800-732-0416

Health Insurance Portability and Accountability Act (HIPAA) Form

AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION
This authorization is intended to comply with the HIPAA Privacy Rule.

Please print.

Name of applicant _____

Date of birth _____ **Social Security number** _____

I authorize any health plan, doctor, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided treatment or services to me or on my behalf ("My Providers"), and any other medical or insurance organization, institution or professional, to disclose my entire medical record and any other health information concerning me, without restriction, to The Prudential Insurance Company of America and its agents, employees and representatives ("Prudential"). This includes medical records and information on diagnoses and/or treatment relating to Human Immunodeficiency Virus (HIV) infection or Acquired Immunodeficiency Syndrome (AIDS), sexually transmitted disease, mental illness, and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

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X Signature of applicant or personal representative _____ Date _____

Description of personal representative's authority or relationship to applicant _____

Keep for your records.

Prudential Financial

The Prudential Insurance Company of America
Prudential Long Term Care Customer Service Center
P.O. Box 8526, Philadelphia, PA 19176-8526 • 1-800-732-0416

Federal HIPAA Notice of Privacy Practices for Protected Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

"We" refers to The Prudential Insurance Company of America in its capacity as a provider of Group and Individual Long Term Care insurance. "You" or "yours" refers to any individual covered by a Long Term Care insurance policy issued by The Prudential Insurance Company of America.

Federal law—meaning the Health Insurance Portability and Accountability Act and related privacy rules—requires The Prudential Insurance Company of America to keep your health information private. We are not allowed to use or disclose it unless we receive your permission or unless permitted by law. Federal law requires us to give you this Notice of our legal duties and privacy practices. This Notice is to inform you of uses and disclosures of your health information that we may make. It also informs you of your rights and our duties with regard to this health information.

We must follow the terms of this Notice. We do reserve the right to change the terms of this Notice and make the new Notice provisions apply to all the health information we keep. This includes health information we had prior to any change in this Notice. We must promptly change this Notice when there is a material change to our uses or disclosures, your rights, our duties and other related circumstances. We will mail you any such revised Notice, unless you have agreed to receive Notices electronically. To receive such Notices by E-mail, you should tell the contact listed at the end of this Notice.

Use and Disclosure of Protected Health Information
Federal law permits us to use and disclose protected health information for purposes of treatment, payment and health care operations as those terms are defined under federal law. As an insurer, we do not provide treatment, but we may use and disclose protected health information for payment purposes, such as in connection with the payment of an insurance claim. We may also use and disclose protected health information for our health care operations such as when we decide to give you insurance or when we renew or replace your insurance. We will also comply with any state or federal law that is more restrictive as to our uses and disclosures of protected health information.

There are also times when federal law permits or requires us to use or disclose your information without your written permission.

Additionally, where appropriate, we may disclose protected health information to a group health plan or plan sponsor in accordance with federal law.

Permitted Disclosures
We may not make all of the uses and disclosures listed here, but federal law permits use or disclosure of your information without your permission:

- When we disclose your information to you.
- To third party non-Prudential business associates that perform services for us or on our behalf, such as vendors.
- Where disclosure is required by law.
- To a public health authority authorized by law to collect or receive your information to prevent or control disease, injury or disability or when reviewing reports of child abuse or for the conduct of other authorized public health activities and responsibilities.
- To a governmental authority when we reasonably believe you may be a victim of abuse, neglect or domestic violence where the governmental authority is allowed by law to have such information.
- To a health oversight agency for such activities.
- For judicial and administrative proceedings.
- To a law enforcement official for a law enforcement purpose.
- To a medical examiner for the purpose of identifying a deceased person, determining the cause of death, or other duties authorized by law.
- To organ donor organizations in order to aid in such donations.
- For certain research purposes authorized by and subject to federal law.
- To avert a serious threat to health or safety.
- To government officials regarding military personnel and certain domestic and foreign government officials for certain functions authorized by federal law.
- To comply with workers' compensation and other similar programs.
- To make certain marketing communications and for certain fundraising purposes.

Required Disclosures
We are required to disclose your information when required by the Secretary of the Department of Health and Human Services to make sure we comply with federal law.

We are also required, with certain exceptions, to provide you with access to inspect and obtain a copy of your information that we keep. See "Your Right To Inspect and Copy Protected Health Information" below.

Need for Authorization
We will not make any uses or disclosures other than those mentioned above without your permission. You may withdraw such permission in writing. Your withdrawal will not be effective (1) if we took action relying on your permission before it was withdrawn, or (2) if we obtained your permission as a condition of issuing you insurance, and the law allows us to contest a claim under the policy or to contest the policy itself. To withdraw your authorization, please write the contact listed at the end of this Notice. If you wish additional information, you should write to the contact listed at the end of this Notice.

Individual Rights with Respect to Your Protected Health Information
FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO REQUEST RESTRICTIONS: You have the right to request that restrictions be placed on certain uses and disclosures of your information. We are not required to agree. If we do agree, we may not use or disclose any of your information except where you need emergency treatment. We may end an agreement to restrict as allowed by federal law. If you wish additional information, you should write to the contact listed at the end of this Notice.

FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO ALTERNATIVE CONFIDENTIAL COMMUNICATION OF PROTECTED HEALTH INFORMATION: If you choose to have your information sent to you by a means of your choice or to an address of your choice, we will do so if the request is reasonable. You must clearly state that disclosure of all or any part of your information could endanger you if not sent per your choice. Any such request should be sent in writing to the contact listed at the end of this Notice. If you wish additional information, you should write to the contact listed at the end of this Notice.

FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO INSPECT AND COPY PROTECTED HEALTH INFORMATION: You have the right to inspect and copy your information, except for any psychotherapy notes, certain information relating to civil, criminal, or administrative proceedings, and certain information prohibited by law from disclosure. We are allowed by law to deny access in some cases, and subject to certain procedures. Any request should be sent in writing to the contact listed at the end of this Notice. If you wish additional information, you should write to the contact listed at the end of this Notice.

FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO AMEND PROTECTED HEALTH INFORMATION: You have the right to request that we amend your information kept in our records. We are allowed to deny your request if we did not create the information in the record. We will review your request and respond to you in writing. All requests should be in writing and sent to the contact listed at the end of this Notice. All requests should provide needed details, including your name, address, insurance policy number, and the reason you think your information needs to be changed. If you wish additional information, you should write to the contact listed at the end of this Notice.

FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO AN ACCOUNTING: You have the right to receive an accounting from us of disclosures of your information made for up to the six (6) years prior to your request. This right does not apply to: disclosures made to carry out treatment, payment, or health care operations; disclosures made with your permission; disclosures made for police purposes; disclosures allowed by law; or disclosures made before April 14, 2003. Any request should be sent to the contact listed at the end of this Notice. If you wish additional information, you should write to the contact listed at the end of this Notice.

FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO A PAPER COPY OF THIS NOTICE: You have the right, even if you have agreed to receive notice by E-mail, to get a paper copy of this Notice. All requests should be in writing and sent to the contact listed at the end of this Notice.

FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO FILE A COMPLAINT. If you believe your privacy rights have been violated, you have the right to complain to us by writing to the contact listed at the end of this Notice or to the Secretary of the U.S. Department of Health & Human Services, Hubert H. Humphrey Building, 200 Independence Avenue, Washington, DC 20201. Federal law prohibits retaliation against you for filing such a complaint. The contact listed at the end of this Notice is also available to provide you information regarding questions you have or other information concerning this Notice.

When you contact us in writing, you should include your name, address, and policy number. The contact to whom you should address your complaint is:

The Prudential Insurance Company of America
Privacy Contact
Long Term Care Customer Service Center
P.O. Box 8519
Philadelphia, PA 19176

Telephone number: 1-800-732-0416

The effective date of this notice is March 1, 2005.

The Prudential Insurance Company of America
Prudential Long Term Care Customer Service Center
P.O. Box 8526, Philadelphia, PA 19176-8526 • 1-800-732-0416

Electronic Funds Transfer Authorization

INSTRUCTIONS

To enroll in Prudential's monthly electronic funds transfer (EFT) payment service, please provide us with the following information. **If you wish to use your checking account, enclose your blank, voided check for that account. If you wish to use your savings account, you must confirm that your financial institution permits electronic fund withdrawals from savings accounts, and obtain your financial institution's transit routing number.** Please note that we cannot obtain acceptable banking information from deposit slips. If you have any questions, please call our Long Term Care Customer Service Center, toll free, at 1-800-732-0416. Please print except where signatures are required. Use blue or black ink.

A APPLICANT/INSURED INFORMATION

Complete information for each applicant for whom this EFT Authorization will be used.

Full name **Policy/Cert. No.** (If known)

Full name **Policy/Cert. No.** (If known)

Please indicate the bill date you prefer:
☐ 1st* ☐ 15th
☐ 8th ☐ 22nd

B BANKING INFORMATION

Name of financial institution

Type of account ☐ Checking ☐ Savings

Financial institution 9-digit transit routing number

Account number

Local branch telephone number ( ) -

Full name of account owner
(If other than applicant/insured)

Relationship to applicant/insured

C EFT PAYMENT SERVICE AUTHORIZATION

I hereby request and authorize The Prudential Insurance Company of America (Prudential) to make electronic fund withdrawals or other forms of pre-authorized withdrawals from my account named above, for payment of the premium due the policy(ies) or certificate(s) indicated above. My signature below is exactly as it appears in my financial institution's records for this account. I agree that withdrawals shall be made approximately 3 to 5 days after the bill date indicated above. I understand that premium notices will not be mailed. I understand that if a withdrawal request is not honored by my financial institution, Prudential shall consider that my premium has not been paid. Any withdrawal returned due to insufficient funds may be re-deposited for collection by Prudential, at its sole discretion.

If this authorization pertains to insurance (or an increase in insurance) for which an application is pending, this authorization shall take effect on the Effective Date of the insurance applied for. This authorization shall not be construed as: (a) an approval by Prudential of that application; or (b) a modification of any provisions of any existing coverage. Otherwise, this authorization shall take effect on the date signed.

Either I or Prudential may cancel this authorization at any time by giving 30 days written notice to the other party. Any notice hereunder will not be deemed effective until Prudential has had a reasonable time to act. I agree that Prudential shall not be liable for any loss, liability, cost or expense for acting on this Authorization.

Full name of account owner

Address (No P.O. Boxes please) **Apt.**

City **State** **ZIP**

X **Applicant's signature** **Date**
(Must be the same as that on file with the Financial Institution)

*If no bill date is selected, the 1st will be the bill date.

Prudential Financial

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P.O. Box 8526, Philadelphia, PA 19176-8526 • 1-800-732-0416

Electronic Funds Transfer Authorization

INSTRUCTIONS

To enroll in Prudential's monthly electronic funds transfer (EFT) payment service, please provide us with the following information. **If you wish to use your checking account, enclose your blank, voided check for that account. If you wish to use your savings account, you must confirm that your financial institution permits electronic fund withdrawals from savings accounts, and obtain your financial institution's transit routing number.** Please note that we cannot obtain acceptable banking information from deposit slips. If you have any questions, please call our Long Term Care Customer Service Center, toll free, at 1-800-732-0416. Please print except where signatures are required. Use blue or black ink.

A APPLICANT/INSURED INFORMATION

Complete information for each applicant for whom this EFT Authorization will be used.

Full name _____ **Policy/Cert. No.** (If known) _____

Full name _____ **Policy/Cert. No.** (If known) _____

Please indicate the bill date you prefer:
☐ 1st* ☐ 15th
☐ 8th ☐ 22nd

B BANKING INFORMATION

Name of financial institution _____

Type of account ☐ Checking ☐ Savings

Financial institution 9-digit transit routing number | | | | | | | | | |

Account number _____

Local branch telephone number ( ) -

Full name of account owner (If other than applicant/insured) _____

Relationship to applicant/insured _____

C EFT PAYMENT SERVICE AUTHORIZATION

I hereby request and authorize The Prudential Insurance Company of America (Prudential) to make electronic fund withdrawals or other forms of pre-authorized withdrawals from my account named above, for payment of the premium due the policy(ies) or certificate(s) indicated above. My signature below is exactly as it appears in my financial institution's records for this account. I agree that withdrawals shall be made approximately 3 to 5 days after the bill date indicated above. I understand that premium notices will not be mailed. I understand that if a withdrawal request is not honored by my financial institution, Prudential shall consider that my premium has not been paid. Any withdrawal returned due to insufficient funds may be re-deposited for collection by Prudential, at its sole discretion.

If this authorization pertains to insurance (or an increase in insurance) for which an application is pending, this authorization shall take effect on the Effective Date of the insurance applied for. This authorization shall not be construed as: (a) an approval by Prudential of that application; or (b) a modification of any provisions of any existing coverage. Otherwise, this authorization shall take effect on the date signed.

Either I or Prudential may cancel this authorization at any time by giving 30 days written notice to the other party. Any notice hereunder will not be deemed effective until Prudential has had a reasonable time to act. I agree that Prudential shall not be liable for any loss, liability, cost or expense for acting on this Authorization.

Full name of account owner _____

Address (No P.O. Boxes please) _____ **Apt.** _____

City _____ **State** _____ **ZIP** _____

X **Applicant's signature** _____ **Date** _____
(Must be the same as that on file with the Financial Institution)

*If no bill date is selected, the 1st will be the bill date.

GRP 112215 Keep for your records.

Prudential Financial

Prudential Financial

The Prudential Insurance Company of America
Long Term Care Unit
P.O. Box 8526
Philadelphia, PA 19176
Tel 800 732-0416

Long-Term Care Insurance
Personal Worksheet

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But, long-term care insurance may be expensive and may not be right for everyone.

By state law, Prudential must fill out part of the information on this worksheet and ask you to fill out the rest to help you and Prudential decide if you should buy this policy.

Premium Information

Policy Form Number(s) _____Contract Series 83500_____

The premium for the coverage you are considering will be $_____ per year.

Type of Policy (noncancellable/guaranteed renewable): Guaranteed renewable

The Company's Right to Increase Premiums: The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.

Rate Increase History

The company has sold long-term care insurance since 1986 and has sold this policy since 2002. The company has never raised its rates for any long-term care insurance policy it has sold in this state or any other state.

Questions Related To Your Income

How will you pay each year's premium? (check one)

☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

Have you considered whether you could afford to keep this policy if the premiums were raised, for example, by 20%?

What is your annual income? (check one)

☐ Under $10,000 ☐ $10,000-20,000 ☐ $20,000-30,000
☐ $30,000-50,000 ☐ Over $50,000

How do you expect your income to change over the next 10 years? (check one)

☐ No change ☐ Increase ☐ Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one) ☐ Yes ☐ No
If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?

☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

The national average annual cost of care in 2003 was $61,000, but this figure varies across the country. In ten years, the national average annual cost would be about $100,000 if costs increase 5% annually.

What elimination period are you considering? Number of days _____
Approximate cost $_____ for that period of care.

How are you planning to pay for your care during the elimination period? (check one)

☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)

☐ Under $20,000 ☐ $20,000-$30,000 ☐ $30,000-$50,000 ☐ Over $50,000

How do you expect your assets to change over the next ten years? (check one)
☐ Stay about the same ☐ Increase ☐ Decrease

If you are buying this coverage to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.

DISCLOSURE STATEMENT

If you are an active employee or the spouse of an active employee, no further action is required. If you are not an active employee or spouse, this must be completed and signed and returned to Prudential in order for us to process your enrollment form.

Check one.

☐ The answers to the questions above describe my financial situation.
or
☐ I choose not to complete this information.

Please check the box.

☐ I acknowledge that I have reviewed this form including the premium, premium rate increase history and potential for premium increases in the future. I understand the above disclosures. **I understand that the rates for this coverage may increase in the future.** (This box must be checked).

Signed: _____ _____

(Applicant) (Date)

Note: In order for us to process your enrollment form, please return this signed statement to Prudential along with your enrollment form. However, if you are an active employee or the employee's spouse, you do not need to return this Personal Worksheet in order for Prudential to process your enrollment form.

Prudential may contact you to verify your answers.

THINGS YOU SHOULD KNOW BEFORE YOU BUY LONG-TERM CARE INSURANCE

Long-Term Care Insurance

- A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.

- You should not buy this insurance policy unless you can afford to pay the premiums every year. Remember that Prudential can increase premiums in the future.

- The Personal Worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare

- Medicare does not pay for most long-term care.

Medicaid

- Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should not buy this policy if you are now eligible for Medicaid.

- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.

- When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance and some of your joint assets.

- Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

Shopper's Guide

- Make sure the insurance company or agent gives you a copy of a book called *A Shopper's Guide to Long-Term Care Insurance* published by the National Association of Insurance Commissioners. Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling

- Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

Prudential Financial

The Prudential Insurance Company of America
Long Term Care Unit
P.O. Box 8526
Philadelphia, PA 19176-8526
Tel 800 732-0416

Long Term Care Insurance
Potential Rate Increase Disclosure Form

1. **Premium Rate:** The premium rate that is applicable to you and that will be in effect until a request is made and filed for an increase is $ _____ (fill in amount from Rate Sheet based on plan design and options you choose).

2. **The premium for this Certificate will be shown on the Confirmation Statement you will receive together with your Certificate of Insurance.**

3. **Rate Schedule Adjustments:** The company will provide a description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.) (fill in the blank): No premium rate or rate schedule adjustments are scheduled for this coverage.

4. **Potential Rate Revisions:** This Certificate is Guaranteed Renewable. This means that the rates for this coverage may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all insureds with coverage similar to yours.

If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

- Pay the increased premium and continue your coverage in force as is.
- Reduce your benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
- Exercise your non-forfeiture option if purchased. (This option may be available for purchase for an additional premium.)
- Exercise your contingent non-forfeiture rights.* (This option may be available if you do not purchase a separate non-forfeiture option.)

***Contingent Non-forfeiture**

If the premium rate for your coverage goes up in the future and you didn't buy a non-forfeiture option, you may be eligible for contingent non forfeiture. Here's how to tell if you are eligible:

You will keep some long term care insurance coverage, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table and

- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you've paid since your coverage was first issued. If you have already received benefits, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Non-forfeiture option, your coverage with this reduced maximum benefit amount will be considered paid up with no further premiums due.

Example:

You bought the coverage at age 65 and paid the $1,000 annual premium for 10 years, so you have paid a total of $10,000 in premium.

In the eleventh year, you receive a rate increase of 50%, or $500 for a new annual premium of $1,500, and you decide to lapse the coverage (not pay any more premiums).

Your paid-up benefits are $10,000 (provided you have at least $10,000 of benefits remaining.)

Contingent Non-forfeiture
Cumulative Premium Increase over Initial Premium
That qualifies for Contingent Non-forfeiture

(Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30 – 34	190%
35 – 39	170%
40 – 44	150%
45 – 49	130%
50 – 54	110%
55 – 59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA
751 BROAD STREET
NEWARK, NEW JERSEY 07102
(800) 732-0416

LONG-TERM CARE INSURANCE OUTLINE OF COVERAGE

Policy Number 83500 Contract Series
Group Contract No. LT-44502-MD

The following applies to applicants who must answer medical questions in order to qualify for the Long Term Care Insurance.

Caution: *The issuance of this long-term care insurance certificate is based upon your responses to the questions on your enrollment form. A copy of your enrollment form is enclosed OR was retained by you when you applied. If your answers are incorrect or untrue, or you fail to include all material medical information requested, Prudential may have the right to deny benefits or rescind your Certificate, subject to the Incontestability provision. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: Prudential Long Term Care Customer Service Center, P. O. Box 8526, Philadelphia, PA 19176.*

Notice to buyer: This certificate may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all plan limitations.

This program has not been approved under the Maryland Partnership for Long Term Care Program under Title 15, Subtitle 4 of the Health - General.

1. This policy is a group policy which was issued in the State of Maryland.

2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the Coverage. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the group policy contains governing contractual provisions. This means that the group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR CERTIFICATE CAREFULLY!

3. FEDERAL TAX CONSEQUENCES**. This Certificate is intended to be a federally tax-qualified long term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.**

4. TERMS UNDER WHICH THE CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED. RENEWABILITY: **THIS CERTIFICATE IS GUARANTEED RENEWABLE**. This means you have the right, subject to the terms of your certificate to continue this certificate as long as you pay your premiums on time. Prudential cannot change any of the terms of your certificate on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY. This coverage may be continued if your coverage ends for any reason other than nonpayment of premiums or exhaustion of the Lifetime Maximum. You may elect to continue the Coverage by paying the applicable premium for it. This Certificate contains a Waiver of Premium provision. After you meet the Benefit Eligibility Criteria and satisfy the required Benefit Waiting/Elimination Period, the premiums for your Coverage will be waived. These features are described in full detail in the Certificate.

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS. **PRUDENTIAL RESERVES THE RIGHT TO CHANGE THE PREMIUM YOU PAY. ANY CHANGE WILL APPLY ON A CLASS BASIS TO ALL INSUREDS.**

6. TERMS UNDER WHICH THE CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED. You may surrender the Certificate without penalty or obligation within 30 days from the date of delivery of the Certificate. If you decide to surrender the certificate, you must provide notice of the surrender to Prudential or its insurance producer. Your notice of surrender will cause the Certificate to be void and without benefit from its beginning. Surrender entitles you to a refund of all monies within 30 business days after receipt by Prudential or its insurance producer of notice of surrender. Upon proper notification of your death or cancellation of this coverage at a time occurring after the 30 day free look period, Prudential will refund on a pro-rata basis any part of the periodic premium contribution for you which applies to the period after cancellation. The Certificate does contain provisions which provide for a refund or partial refund upon the death of the insured. Please refer to the section entitled “Additional Features” which describes the Death Benefit.

7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the *Guide to Health Insurance for People with Medicare* available from Prudential by calling 1-800-732-0416. Prudential is not representing Medicare, the federal government or any state government.

8. LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home. This Certificate provides coverage in the form of reimbursement benefits, according to the Plan you choose, for covered long term care expenses, subject to Benefit Waiting/Elimination Period and Daily Maximum, Calendar Year and Lifetime Maximum benefits.

9. BENEFITS PROVIDED BY THIS CERTIFICATE. This Certificate pays benefits for Eligible Charges incurred by you for Institutional Care which includes Nursing Home Care, Assisted Living Facility Care, and Bed Reservation; Home and Community-Based Care, which includes Home Health Care and Adult Day Care; and Additional Benefits which includes Hospice Care, Respite Care, Independence Support, Caregiver Training, Information and Referral Services, Private Care Management and Alternate Plan of Care. Benefits paid for Eligible Charges count towards fulfillment of your Lifetime Maximum, unless otherwise stated. The actual amount paid depends on the Plan you have chosen. You may choose one of the following Plans.

THE STATE EMPLOYEE'S AND RETIREE'S
HEALTH AND WELFARE BENEFITS PROGRAM
LONG TERM CARE PLAN SCHEDULE OF BENEFITS

Benefit Elimination/Waiting Period	90 Days			
	Plan 1	**Plan 2**	**Plan 3**	**Plan 4**
INSTITUTIONAL CARE BENEFITS				
NURSING HOME CARE				
Up to the *Daily Maximum* for *Nursing Home* Care	$85	$100	$150	$200
ASSISTED LIVING FACILITY CARE				
Up to the *Daily Maximum* for *Assisted Living Facility* Care	$85	$100	$150	$200
BED RESERVATION				
Up to the *Daily Maximum* for *Bed Reservation*	$85	$100	$150	$200
21 Day Benefit Limit per *Calendar Year*	$1,785	$2,100	$3,150	$4,200
HOME & COMMUNITY-BASED CARE BENEFITS*				
HOME HEALTH CARE				
Up to the *Daily Maximum* for *Home Health Care*	$43	$50	$75	$100
ADULT DAY CARE				
Up to the *Daily Maximum* for *Adult Day Care*	$43	$50	$75	$100
ADDITIONAL BENEFITS				
HOSPICE CARE				
Up to the *Daily Maximum* for *Hospice Care*	$85	$100	$150	$200
RESPITE CARE				
Up to the *Daily Maximum* for *Respite Care*	$85	$100	$150	$200
21 Day *Calendar Year* Benefit Limit	$1,785	$2,100	$3,150	$4,200
100 Day Lifetime Benefit Limit	$8,500	$10,000	$15,000	$20,000

	Plan 1	Plan 2	Plan 3	Plan 4
INDEPENDENCE SUPPORT				
Independence Support Lifetime Benefit Limit	$4,250	$5,000	$7,500	$10,000
CAREGIVER TRAINING				
Caregiver Training Lifetime Benefit Limit	$500	$500	$500	$500
INFORMATION AND REFERRAL SERVICES				
Information and Referral by *Prudential*	No limit	No limit	No limit	No limit
PRIVATE CARE MANAGEMENT				
Private Care Management Calendar Year Benefit Limit	$1,020	$1,200	$1,800	$2,400
ALTERNATE PLAN OF CARE	Paid at the discretion of Prudential			
LIFETIME MAXIMUM**				
Maximum Benefit Period				
Three (3) Years	$93,075	$109,500	$164,250	$219,000
Six (6) Years	$186,150	$219,000	$328,500	$438,000

***** The benefits paid for all covered *Home & Community-Based Care* services received on any given day will not exceed the *Daily Maximum* benefit for *Home Health Care*.

****** For all *Long Term Care* During Your Lifetime. Your Lifetime Maximum is based on the Maximum Benefit Period you select. There are two options available to you: 3 years and 6 years. The Lifetime Maximum is equal to the *Daily Maximum* for care in a *Nursing Home* you chose, times 365 days, times the Maximum Benefit Period you chose. For example, electing the $85 *Daily Maximum* for care in a *Nursing Home* and the Six Year Maximum Benefit Period provides a *Lifetime Maximum* of $186,150 ($85 x 365 x 6).

Benefit Waiting/Elimination Period. A Benefit Waiting/Elimination Period must be met once during your lifetime before benefits are payable. This Certificate has one combined Benefit Waiting/Elimination Period for all covered services, except Hospice Care, Independence Support, Caregiver Training, Information & Referral and Private Care Management. This is a period, counted in calendar days, which begins on the date you are assessed, if that assessment results in eligibility for benefits and continues as long as you have a Chronic Illness or Disability. You do not need to incur charges to satisfy the Benefit Waiting/Elimination Period. The Benefit Waiting/Elimination Period can be satisfied over multiple periods of Chronic Illness or Disability. The Benefit Waiting/Elimination Period is shown in the Schedule of Benefits above.

Eligibility for Payment of Benefits. In order to receive benefits, you must be assessed by an Assessor and be confirmed as having a Chronic Illness or Disability. A Chronic Illness or Disability is one in which there is

1) A loss of the ability to perform, without Substantial Assistance, at least two Activities of Daily Living. This loss must be expected to continue for 90 days. Activities of Daily Living are Bathing, Continence, Dressing, Eating, Toileting and Transferring; or

2) A severe Cognitive Impairment, which requires Substantial Supervision to protect you from threats to health and safety.

Unless within the preceding 12-month period a *Licensed Health Care Practitioner* certified that you meet the requirements above, you will not be considered to have a *Chronic Illness or Disability* if you otherwise meet these requirements.

Activities of Daily Living are defined as follows.

Bathing – Washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.

Continence – The ability to maintain control of bowel and bladder function or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

Dressing – Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

Eating – Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by feeding tube or intravenously.

Toileting – Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

Transferring – Sufficient mobility to move into or out of a bed, chair or wheelchair or to move from place to place, either by walking, using a wheelchair or by other means.

Cognitive Impairment is defined as follows. A deficiency in an individual's short or long-term memory, orientation as to person, place, and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

Prudential will arrange for a trained Assessor to assess you or you may select your own Assessor. The assessment will be based on objective standards of measurement. Based on the information obtained during the assessment, your eligibility will be confirmed or denied based on Prudential's use of objective standards of measurement. If you are eligible, you will need a Plan of Care. Your Plan of Care will be used to determine benefits based on the Plan you have chosen.

10. LIMITATIONS AND EXCLUSIONS**. Charges Not Covered:**

a) Work-connected Conditions Charge. A charge covered by a workers' compensation law, occupational disease law or similar law.

b) Government Plan Charge. A charge for a service or supply:

(A) furnished by or for the United States government or any other government, unless payment of the charge is required by law; or

(B) to the extent that the service or supply, or any benefit for the charge, is provided by any law or governmental plan under which the patient is or could be covered. This (B) does not apply to a state plan under Medicaid or to any law or plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program. When this (B) applies to Medicare, the benefits provided by Medicare will be deemed to include any amount that would have been payable by Medicare in the absence of a deductible or coinsurance requirement under that program.

c) War, Felony, Riot or Insurrection. Charges for a condition due to war or any act of war while you are insured or due to your participation in an act of felony, riot or insurrection. "War" means declared or undeclared war and includes resistance to armed aggression. "Riot" means a wild, violent, public disturbance of the peace.

d) Self-inflicted Injury or Suicide. Charges arising from intentionally self-inflicted injury or attempted suicide, while sane or suffering from inorganic based insanity.

e) Services and Supplies Outside the United States. Charges for services or supplies outside of the United States and its possessions.

f) Treatment for Chronic Alcoholism or Chemical Dependency. Charges in connection with the treatment of chronic alcoholism or chemical dependency.

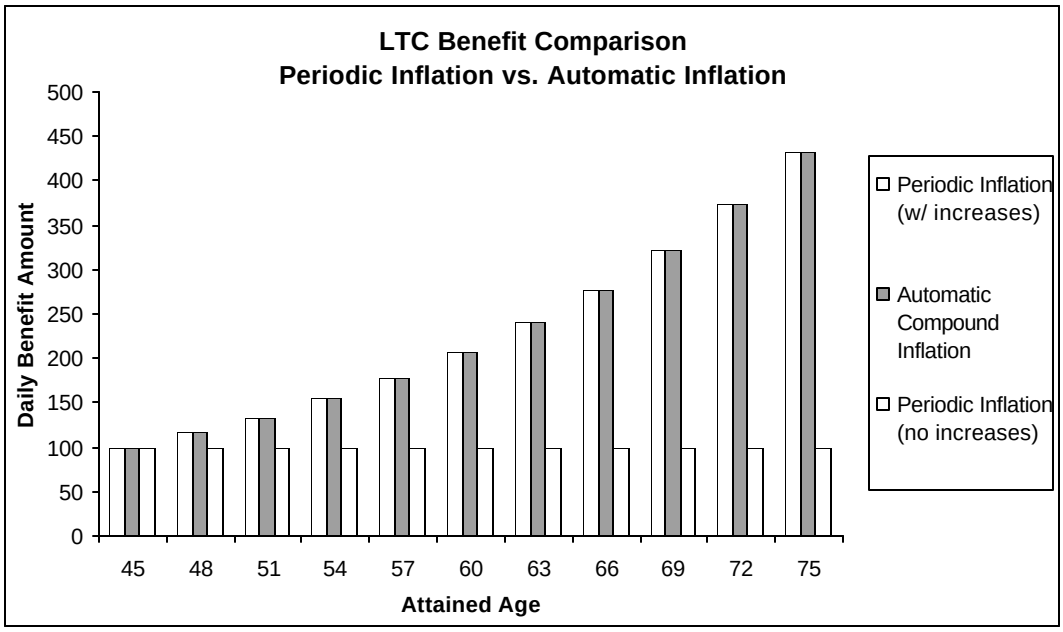
THIS CERTIFICATE MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG TERM CARE NEEDS.

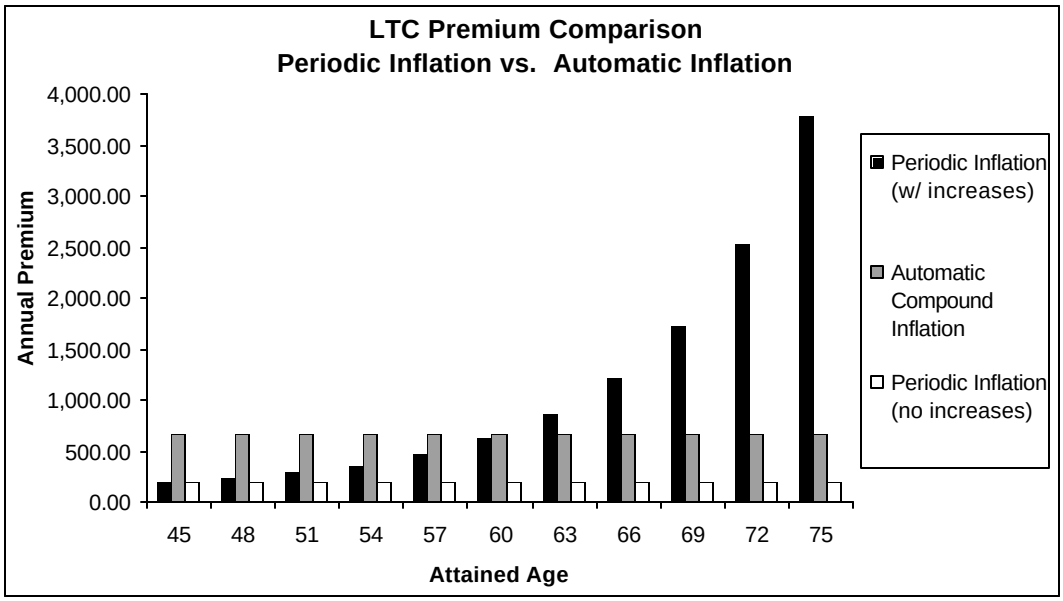
11. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of Long Term Care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. Benefit levels may increase over time in accordance with the inflation protection provision you choose.

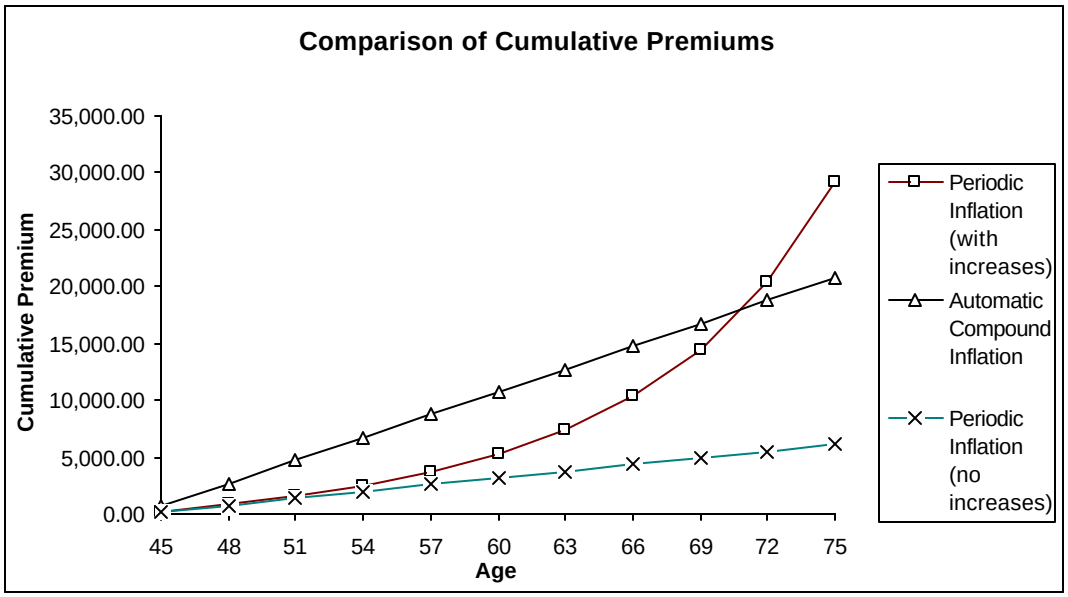
Periodic Offers for Inflation Increase Protection. At least every three years, you will be offered the opportunity to increase your benefits to keep up with inflation. If you accept the offer, the amount of the additional benefit shall be the difference between your existing benefits and those benefits compounded annually at a rate of at least five percent for the period beginning with the purchase of your existing benefits and extending until the year in which the offer is made. Benefits will be rounded to the nearest dollar. Your Lifetime Maximum will also increase accordingly.

Your age on the Effective Date of the increase will be used to determine the additional separate premium for the increased Coverage. Therefore, your premium will increase each time you accept an inflation protection offer. You do not have to provide evidence of insurability to take inflation increases. However, if you decline the previous two offerings made to you, and then want to increase Coverage, you will be required to submit satisfactory evidence of insurability the next time you accept an offer.

Optional Inflation Rider Available for Additional Premium-
Automatic Compound Inflation Increases Protection. Your benefits will automatically increase on the anniversary of the Effective Date of your Coverage. These increases will occur even if you are receiving benefits. Each year, all benefits increase by 5% compounded annually, rounded to the nearest dollar. Your Lifetime Maximum will also increase accordingly. You do not have to provide evidence of insurability. No additional premium charge will be imposed.







12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS. This Certificate provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses.

13. PREMIUM. Premiums vary according to the Plan you choose. The initial premium for your Coverage will be determined from the premium rate schedules contained in your enrollment material based on the Plan selected and your age as of the date you enroll.

14. ADDITIONAL FEATURES.

Medical Underwriting. Medical underwriting is used to determine eligibility for Coverage. To enroll for Coverage under this plan, you must complete an Enrollment Form. Satisfactory evidence of good health may be required for certain applicants in order to be eligible for this Coverage. Please see the Plan Details and Instructions in the Enrollment Kit. Individuals over the age of 84 are not eligible.

Third Party Lapse Designee. Unless you decline to do so in your Enrollment Form, you have the right to name a third party as your authorized designee to be notified when the lapse of your coverage is imminent. It is our responsibility to notify you and this designee prior to canceling your Coverage due to lack of premium payment. Notice will not be given until 30 days after a premium is due and unpaid. You may change your designee at any time by notifying Prudential in writing.

Reinstating Coverage. If you fail to pay your premium and your Coverage ends for this reason, you may be eligible to reinstate your Coverage. You may make a request for reinstatement within 60 days of the date premiums were due. If, due to your Chronic Illness, you fail to pay your premium and your Coverage ends for this reason, you may be eligible to reinstate your Coverage. You or your representative may request reinstatement within five months of the date premiums were due.

15. OPTIONAL BENEFITS THAT ARE AVAILABLE TO YOU FOR ADDITIONAL PREMIUM.

Non-Forfeiture Benefit - Shortened Benefit Period Rider: This rider provides a non-forfeiture benefit in the form of a shortened benefit period. This rider will pay benefits according to the conditions in effect at the time insurance ended, up to the benefit limits you have chosen. However, you will have a reduced Lifetime Maximum.

This benefit can be used at any time during your lifetime until the reduced Lifetime Maximum is exhausted. If your insurance ended due to non-payment of premium on or after the fifth anniversary of your Effective Date, you may be entitled to receive benefits under this provision. However, you must request benefits and Prudential must determine your eligibility. Your benefits will be based on the Daily Maximums in effect at the time your insurance ended.

Should you elect this optional rider, a table of shortened benefit periods for your Coverage will be provided when you receive your Certificate of Insurance.

16. CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG TERM CARE INSURANCE CERTIFICATE.

17. **SENIOR COUNSELING PROGRAMS.** Please refer to *A Shopper's Guide To Long Term Care Insurance* contained in your enrollment material for the telephone number of the Senior Counseling Program in your state.

STATE OF MARYLAND AGENCY REFERENCE SHEET APRIL 2006

AGENCY	AGENCY CODE	PAYROLL CODE	BENEFIT COORDINATOR		TELEPHONE
AFSCME COUNCIL 92	90.00.28	S	CATHRYN	ACTON	410-547-1515
AGING, OFFICE ON	23.01.07	R	JUDY	QUAMINA	410-767-1079
ALFRED D NOYES CHILDREN CTR	40.06.37	R	BONNIE	MARINE-STINNETT	(410) 792-4253
ALLEGANY COUNTY DISTRICT COURT	22.01.51	R	KATHLEEN	STAFFORD	(301) 723-3104
ALLEGANY COUNTY DSS	33.07.00	R	KIMBERLY	O'BAKER	(301) 784-7174
ALLEGANY COUNTY HEALTH DEPARTMENT	32.06.02	R	DIANE	WILLIAMSON	301-777-5662
ALLEGANY COUNTY REGISTER OF WILLS	50.02.01	R	HARRIET	MORAN	301-724-3760
ANNE ARUNDEL CO REGISTER OF WILLS	50.02.02	R	TERRI	TUERS	410-222-1430
ANNE ARUNDEL CO SUPPORT ENFORCEMENT	33.07.00	R	DEBBIE	FISHER (SC)	(410) 222-2845
ANNE ARUNDEL COUNTY DSS	33.07.00	R	BRENDA	KLEBAHN	(410) 269-4636
ANNE ARUNDEL COUNTY HEALTH DEPT	32.06.02	R	SHERI	LITTLE	410-222-4493
APPALACHIAN REGIONAL COMMISSION	90.00.24	S	LINDA	GANDARA	202-884-7714
ARCHIVES, MARYLAND STATE	23.01.10	R	RICHARD	RICHARDSON	(410) 260-6407
ATTORNEY GENERAL, OFFICE OF THE	22.03.00	R	DIANA	ROTHAGE	410-576-6353
ATTORNEY GRIEVANCE COMMISSION	90.00.01	S	DEBRA	ZACHRY	410-514-7051
BALTIMORE CITY CIRCUIT COURT	22.01.24	R	GRACE	WATTS	(410) 333-3800
BALTIMORE CITY COMMUNITY COLLEGE	36.03.00	R	SUE	TRAVIS	(410) 462-8487
BALTIMORE CITY DSS	33.07.00	R	DOROTHY	KENNEDY	(443) 423-4284
BALTIMORE CITY REGISTER OF WILLS	50.02.24	R	PATRICIA	CASLER	410-752-5131
BALTIMORE COUNTY	33.07.00	R	AMY	URBANIK	(410) 561-3740
BALTIMORE COUNTY CIRCUIT COURT	22.01.03	R	BARBARA	RAINE	410-887-2697
BALTIMORE COUNTY DSS	33.07.00	R	DEBBIE	ASHBURN	(410) 853-3901
BALTIMORE COUNTY HEALTH DEPARTMENT	32.06.02	R	CHRIS	KIRSCHNER	410-887-2702
BALTIMORE COUNTY REGISTER OF WILLS	50.02.03	R	IRENE	DUNAWAY	(410) 887-6691
BALTIMORE HEALTHCARE ACCESS	95.00.19	S	BRIGETTE	MORROW	(410) 649-0521
BALTIMORE MENTAL HEALTH SYSTEMS	95.00.16	S	LAWRENCE	MANNING	410 837-2647
BALTIMORE METROPOLITAN COUNCIL	90.00.26	S	SANDY	SPEARS	410-732-9562
BAY SHORE SERVICES, INC	95.00.30	S	MARY	VOGELER	(410) 341-0307
BLIND INDUSTRIES & SERVICES OF MD	90.00.02	S	STACEY	KAPLAN	(410) 737-2600
BOWIE STATE UNIVERSITY	36.02.23	R	CHEVONIE	LOGAN	(301) 860-4650
CALVERT COUNTY CIRCUIT COURT	22.01.04	R	DANA	FLOYD	410-535-1660
CALVERT COUNTY DSS	33.07.00	R	SYDNA	BUCKMASTER	(443) 550-6998
CALVERT COUNTY HEALTH DEPARTMENT	32.06.02	R	SHARON	WALSER	410-535-5400 X308
CALVERT COUNTY REGISTER OF WILLS	50.02.04	R	MILDRED	COX	410-535-0121
CANAL PLACE PRESERVATION &	23.28.00	R	MICHELLE	CRABTREE	301-724-3655
CAROLINE CO REGISTER OF WILLS	50.02.05	R	BARBARA	PORTER	410-479-0717
CAROLINE COUNTY CIRCUIT COURT	22.01.05	R	F. DALE	MINNER	410-479-1811
CAROLINE COUNTY DSS	33.07.00	R	SANDY	FRANZ	(410) 819-4513
CAROLINE COUNTY HEALTH DEPARTMENT	32.06.02	R	KELLY	REED	(410) 479-8030
CARROLL COUNTY CIRCUIT COURT	22.01.06	R	DEBORAH	BOOG-SHERMAN	410-386-2643
CARROLL COUNTY DSS	33.07.00	R	CATHY	TIBBS	(410) 386-3301
CARROLL COUNTY HEALTH DEPARTMENT	32.06.02	R	PATRICIA	MCCLOUD	(410) 876-4986
CARROLL COUNTY REGISTER OF WILLS	50.02.06	R	PAUL	ZIMMERMANN	410-876-3158
CECIL COUNTY CIRCUIT COURT	22.01.07	R	GAIL	PURNELL	410-996-5371
CECIL COUNTY DSS	33.07.00	R	JOHN	CALEB	(410) 996-0312
CECIL COUNTY HEALTH DEPARTMENT	32.06.02	R	CARMEN	JORDAN	410-996-5550
CHARLES COUNTY CIRCUIT COURT	22.01.08	R	LINDA	TURNER	301-932-3225
CHARLES COUNTY DSS	33.07.00	R	JAYNE	FOLKMAN	(301) 392-6620
CHARLES COUNTY HEALTH DEPARTMENT	32.06.02	R	MICHELE	PIERRE	(301) 609-6914
CHARLES COUNTY REGISTER OF WILLS	50.02.08	R	CHRIS	ESTEVEZ	301-932-3345
CHELTENHAM YOUTH FACILITY	40.02.11	R	CYNTHIA	FRANCIS-JONES	(301) 396-4340
CHESAPEAKE BAY COMMISSION	90.00.03	S	PAULA	HOSE	410-263-3420
CHESAPEAKE CENTER, INC	95.00.15	S	ALETA	MATTHEWS	(410) 822-4122
CITY OF GLENARDEN	95.00.29	S	FOLLY	KUEVEY	(301) 773-2100
CITY OF HYATTSVILLE	90.00.04	S	MARY ELLEN	HARDING	301-985-5010
CLERK CIRCUIT COURT ANNE ARUNDEL CO	22.01.02	R	ROBIN	CUMMINGS	(410) 222-1895
CLERK OF THE CIRCUIT COURT	22.01.15	R	BRENDA	MILLETTE	(240) 777-9465
CLERK OF THE CIRCUIT COURT HARFORD	22.01.12	R	MARY	BICKFORD	410-638-3040
CLERK OF THE CIRCUIT CT ST MARY'S	22.01.18	R	RITA	CULLINS	(301) 475-7844
CLERKS OFFICE OF ALLEGANY COUNTY	22.01.01	R	DAWNE	LINDSEY	301-777-5923
CLIFTON T PERKINS HOSPITAL	32.12.10	R	ELAINE	McCREADY	(410) 724-3015
CLIFTON T. PERKINS HOSPITAL	32.12.10	R	MICHAEL	FAULKNER	410-724-3014
COLLEGE SAVINGS PLANS OF MARYLAND	36.08.00	R	AZRIEL	OSOFSKY	410-767-2965
COMMISSIONERS OF PRESTON	90.00.25	S	ANN	WILLIS	410-673-7929
COMPTROLLER OF MARYLAND	24.01.01	R	JEANETTE	HYRE	(410) 260-7969
COPPIN STATE COLLEGE	36.02.27	R	LUCY M.	GOODE	(410) 951-3669
COPPIN STATE UNIVERSITY	36.02.27	R	BERNEDETTE	BELL	(410) 951-3664
CORRECTIONAL INSTITUTE FOR WOMEN	35.02.05	R	LINDA	THOMPSON	(410) 379-3809

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DEER'S HEAD CENTER	32.09.04	R	PATRICIA	BLACKWELL	(410) 543-4041
DELMARVA COMMUNITY SERVICES	95.00.07	S	JENNIFER	WILLEY	410-221-1900
DEPART. OF BUDGET & MGMT./BALTIMORE	25.01.00	R	TRUDY	HALL	(410) 767-2244
DEPARTMENT OF HUMAN RESOURCE/CCA	33.01.01	R	LARRY	GLOSE	410-767-6959
DEPARTMENT OF JUVENILE JUSTICE	40.01.01	R	PAULINE	FORNEY	(410) 230-3461
DEPARTMENT OF NATURAL RESOURCES	30.01.01	R	SUSAN	MAANS	410-260-8079
DEPT LABOR LICENSING & REGULATION	34.01.01	R	CONNIE	PAYLOR	410-767-2963
DEPT OF ASSESSMENTS & TAXATION	24.03.00	R	SHIRLEY	TINKLER-SHORTER	(410) 767-2941
DEPT OF BUSINESS & ECONOMIC DEVEL	38.01.01	R	LETTIE	HAYNES	(410) 767-3385
DEPT OF HEALTH & MENTAL HYGIENE	32.01.01	R	BETH	REID	(410) 767-6405
DEPT OF HUMAN RESOURCES HRDT	33.05.01	R	KEN	CRISPENS	(410) 767-8807
DEPT. OF JUV. JUSTICE YOUTH CENTER	40.06.31	R	MARIE	WAGONER	301-777-2492
DEPT. OF THE MILITARY	23.08.01	R	LIL	BROWN	(410) 234-3829
DIVISION OF CORRECTIONS HQ.	35.02.01	R	BEVERLY	STREAT	410-585-3355
DIVISION OF PAROLE & PROBATION	35.03.02	R	ILENE	RIVKIN	(410) 585-3569
DORCHESTER COUNTY CIRCUIT COURT	22.01.09	R	LINDA	POWLEY	(410) 228-0481
DORCHESTER COUNTY DSS	33.07.00	R	LAURELLEN	MILLS	(410) 901-4130
DORCHESTER COUNTY HEALTH DEPT.	32.06.02	R	DOROTHY	ELZEY	(410) 901-8139
DORCHESTER COUNTY REGISTER OF WILLS	50.02.09	R	TERESA	WHEATLY	410-228-4181
EASTERN CORRECTIONAL INSTITUTE	35.02.07	R	PAULA	BRITTINGHAM	(410) 845-4056
EASTERN SHORE AREA HEALTH EDUC CTR	95.00.11	S	TINA	WATSON	410-221-2600
EASTERN SHORE HOSPITAL CENTER	32.12.07	R	CASSANDRA	STANLEY	(410) 221-2327
ETHICS COMMISSION, STATE	23.01.05	R	BARBARA	WHEELER	410-974-3071
EXECUTIVE DEPARTMENT	23.01.01	R	BARBARA	WHEELER	410-974-3071
FINAN HOSPITAL CENTER/BRADENBURG	32.13.09	R	PAULA	BRODE	(301) 777-2236
FIRE PREVENTION COMMISSION	41.01.02	R	LINDA	SMITH	(410) 653-8980
FOOD CENTER AUTHORITY, MARYLAND	23.14.00	R	ROSE	HARRELL	410-379-5760
FOR ALL SEASONS, INC	95.00.17	S	ELLEN	MIELKE	(410) 822-1018
FORUM FOR RURAL MARYLAND	23.30.00	R	STEVEN	MCHENRY	(410) 767-6518
FREDERICK COUNTY CIRCUIT COURT	22.01.10	R	LYNDA	BYRD	(301) 694-1908
FREDERICK COUNTY DSS	33.07.00	R	VERONICA	MICHIE	(301) 694-2401
FREDERICK COUNTY HEALTH DEPARTMENT	32.06.02	R	LEE	ELY	301-631-3128
FREDERICK COUNTY REGISTER OF WILLS	50.02.10	R	MICHAEL	TUCKER	301-663-3722
FROSTBURG STATE UNIVERSITY	36.02.26	R	ROSEMARY	HALL	301-687-4398
GARRETT COUNTY CIRCUIT COURT	22.01.11	R	SONDRA	BUCKEL	301-334-1937
GARRETT COUNTY DSS	33.07.00	R	ROBERTA	BAKER	301-533-3028
GARRETT COUNTY HEALTH DEPARTMENT	32.06.02	R	TERRY	RILEY	(301) 334-7770
GARRETT COUNTY LIGHTHOUSE, INC	95.00.24	S	VICKI	MEYERS	(301) 334-9126
GARRETT COUNTY REGISTER OF WILLS	50.02.11	R	RITA	WATSON	301-334-1999
GENERAL SERVICES, DEPARTMENT OF	28.01.01	R	LINDA	GREGORY	410-767-4985
HARFORD COUNTY DSS	33.07.00	R	BARBARA	FINCHAM	410-836-4952
HARFORD COUNTY HEALTH DEPARTMENT	32.06.02	R	MARTHA	BALDERSON	(410) 879-2404
HIGHER ED, LABOR RELATIONS BOARD	36.07.00	R	BARBARA	WHEELER	(410) 974-3071
HISTORIC ST. MARY'S CITY COMMISSION	23.02.01	R	SALLY	DAVIS	(240) 895-4309
HOLLY CENTER	32.13.05	R	SUSAN	HORNER	410-572-6338
HOUSING & COMM. DEVEL., DEPT. OF	37.01.20	R	CATHERINE	GLOVER	(410) 514-7024
HOWARD COUNTY CIRCUIT COURT	22.01.13	R	KATHERINE	BEANE	410-313-3825
HOWARD COUNTY DSS	33.07.00	R	CATHY	WENZEL	(410) 872-4200
HOWARD COUNTY HEALTH DEPARTMENT	32.06.02	R	JANET	PERRONE	(410) 313-6361
HOWARD COUNTY REGISTER OF WILLS	50.02.13	R	HAZEL	HEFFNER	(410) 313-3702
INJURED WORKERS INSURANCE FUND	95.00.18	S	JAIMIE	FAULKNER	(410) 494-2048
JUDICIARY HUMAN RESOURCES	22.01.00	R	TRACEY	SMITH	(410) 260-1289
JUDICIARY HUMAN RESOURCES	22.01.00	R	KAREN	KOTSCHENREUTHER	410 260-1281
JUDICIARY HUMAN RESOURCES	22.01.00	R	MONICA	JACKSON	410 260-1288
JUDICIARY HUMAN RESOURCES	22.01.00	R	DEBBIE	VLNA	(410) 260-1209
KENT COUNTY CIRCUIT COURT	22.01.14	R	SHERISE	HYNSON	410-778-7431
KENT COUNTY DSS	33.07.00	R	JANE	SLEVIN	(410) 810-7701
KENT COUNTY HEALTH DEPARTMENT	32.06.02	R	TERRY	MILASH	410-778-7033
KENT COUNTY REGISTER OF WILLS	50.02.14	R	ELLEN	LANE	410-778-7465
KEY POINT HEALTH SERVICES	95.00.20	S	JANE	JENSEN	(443) 625-1585
LEGAL AID BUREAU, INC.	95.00.26	S	LINDA	BROOKS	(410) 951-7718
LEGAL AID BUREAU, INC.	95.00.26	S	LINDA	BROOKS	(410) 951-7718
MARYLAND AUTOMOBILE INSURANCE FUND	23.10.00	R	SUE	EVANS	410-269-4333
MARYLAND DEPARTMENT OF PLANNING	23.23.01	R	CHERYL	MURPHY	(410) 767-4619
MARYLAND DEPARTMENT OF PLANNING	23.23.01	R	JOYCE	LIMA	(410) 767-4518
MARYLAND ENVIRONMENTAL SERVICE	90.00.21	S	DONNA	OLIFF	(410) 729-8232
MARYLAND GENERAL ASSEMBLY	21.01.01	R	ROBYN	O'CONNOR	410-946-5120
MARYLAND HEALTH CARE FOUNDATION	95.00.13	S	MARILYN	MAULTSBY	(410) 998-2038

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MARYLAND HIGHER ED COMMISSION	36.09.00	R	BETTY	MCGRANE	(410) 260-4508
MARYLAND HOUSE OF CORRECTION	35.02.02	R	JODEE	MALDONADO	(410) 540-6468
MARYLAND INSURANCE ADMINISTRATION	23.26.01	R	TERESA	HIEWSKY	(410) 468-2463
MARYLAND LEGAL SERVICES CORPORATION	90.00.19	S	SUSAN	LENTZ	410-576-9494
MARYLAND PAROLE COMMISSION	35.03.01	R	ERIN	ALSTON	(410) 585-3054
MARYLAND PORT ADMINISTRATION	29.02.01	R	NANCY	LAWLOR	410-631-1032
MARYLAND STADIUM AUTHORITY	23.01.03	R	BERNADETTE	BURGHARDT	410-333-1560
MARYLAND STATE LOTTERY AGENCY	24.04.00	R	LARRY	SIMPSON	(410) 230-8767
MARYLAND STATE LOTTERY AGENCY	24.04.00	R	TROY	PARHAM	(410) 230-8767
MARYLAND STATE POLICE	41.01.01	R	TRACY	MOULTRIE	(410) 653-4221
MARYLAND TRANSPORTATION AUTHORITY	29.02.01	R	JENNIFER	HUTH	(410) 288-8437
MARYLAND VETERANS' HOME COMMISSION	23.17.00	R	SHARON	MATTIA	301-884-8171
MASS TRANSIT ADMINISTRATION	29.02.01	R	JANE	BURRESS	(410) 767-3849
MASS TRANSIT ADMINISTRATION	90.00.17	S	JANE	BURRESS	(410) 767-3849
MD AFRICAN AMERICAN MUSEUM CORP.	37.02.01	R	JUNIUS	RANDOLPH	(443) 263-1807
MD AVIATION ADMINISTRATION	29.02.01	R	DANA	BYRD	(410) 859-7007
MD AVIATION ADMINISTRATION	29.02.01	R	TOWANDA	BASKIN	(410) 859-7008
MD BUSINESS ENTERPRISE PROGRAM	90.00.23	S	JENSINE	CUMMINGS	410-554-9452
MD CLASSIFIED EMPLOYEES ASSOCIATION	90.00.09	S	MICHAEL	KNIGHTON	410-298-8800X 208
MD COMMISSION ON HUMAN RELATIONS	23.12.00	R	JAY	SYBERT	(410) 767-8567
MD CORRCTIONAL INST-HAGERSTOWN	35.02.04	R	JETA	EWING	240 420-1376
MD CORRECTIONAL ADJUSTMENT CENTER	35.02.03	R	KIM	COLLICK-VICE	(410) 625-5205
MD CORRECTIONAL INST. - HAGERSTOWN	35.02.04	R	CHARLENE	BUTTS	(240) 420-1375
MD CORRECTIONAL INSTITUTE-JESSUP	35.02.02	R	LATRECE	EPPS	(410) 540-6747
MD CORRECTIONAL PRE-RELEASE SYSTEM	35.02.06	R	ANNA	SIMS	(410) 540-6262
MD CORRECTIONAL TRAINING CENTER	35.02.04	R	MARCY	CLINE	(240) 420-1412
MD CRIME VICTIMS' RESOURCE CTR, INC	95.00.31	S	REGINA	RAWNSLEY	(301) 952-0063
MD DEPARTMENT OF AGRICULTURE	31.01.11	R	MARY	DARLING	410-841-5840
MD DEPARTMENT OF THE ENVIRONMENT	39.01.01	R	SHERYL	HAGOOD	(410) 537-3105
MD DEPARTMENT OF TRANSPORTATION	29.02.01	R	NANCY	ALLEN	410-865-1193
MD DEPT OF VETERANS AFFAIRS	23.15.00	R	ROSE	BEAN	410-333-4428
MD DISABILITY LAW CENTER, INC.	90.00.20	S	CHERYL	MOLYNEAUX	(410) 727-6352
MD EMERGENCY MANAGEMENT AGENCY	23.08.01	R	SANDRA	SIEGLEIN	410-517-5121
MD HEALTH & HIGHER ED. FAC. AUTH.	90.00.06	S	STEPHANIE	TAYLOR-BURRELL	410-837-6220
MD HOUSE OF CORRECTIONS-ANNEX	35.02.02	R	MARILIA	SCANLAN	(410) 540-6312
MD HOUSE OF CORRECTIONS-ANNEX	35.02.02	R	THOMASINE	JOHNSON	(410) 540-6312
MD RECEPTION & DIAGNOSTIC CENTER	35.02.03	R	MARY	CHAMBERS	(410) 878-4108
MD SCHOOL FOR THE DEAF/COLUMBIA	36.05.02	R	DONALD	HALL	(410) 480-4517
MD SCHOOL FOR THE DEAF/FREDERICK	36.05.01	R	KAY	SPRIGGS	(301) 360-2008
MD STATE BOARD OF CONTRACT APPEALS	23.19.00	R	LONI	HOWE	(410) 767-8228
MD TEACHERS & STATE EMPLOYEES	26.12.00	R	ANNA MARIE	SMITH	(410) 767-8731
MD WORKER'S COMPENSATION COMMISSION	22.06.00	R	DOUGLAS	MORIN	(410) 864-5232
METROPOLITAN TRANSITION CENTER	35.02.03	R	RODNEY	BURGER	410-230-1412
MIDSHORE MENTAL HEALTH	95.00.09	S	ASHLEY	VACEK	410-770-4801
MIEMSS	23.27.00	R	ROBERT	DUBANSKY	(410) 706-0470
MILITARY, DEPT. OF	23.08.01	R	DEBRA	PORTS	(410) 234-3832
MONTGOMERY CO CHILD SURRPORT	33.07.00	R	MICHELLE	BURRILL	(301) 610-4608
MONTGOMERY CO. DEPT OF SOCIAL SVS	95.00.10	S	BELINDA	FULCO	(240) 777-5076
MONTGOMERY COUNTY HEALTH DEPARTMENT	32.06.02	R	JUDITH	UNGER	240 777-3310
MONTGOMERY COUNTY REGISTER OF WILLS	50.02.15	R	MELISSA	KEYSER	(240) 777-9671
MORGAN STATE UNIVERSITY	36.13.00	R	MARIE	ARMSTRONG	(443) 885-4413
MOTOR VEHICLE ADMINISTRATION	29.02.01	R	SARA	RICHARDS	410-768-7337
MSDE- DN OF REHAB. SERVICES (DORS)	36.01.01	R	LINDA	WATTS	(410) 554-9393
MSDE HEADQUARTERS	36.01.01	R	DENICE	CLARK	(410) 767-0153
NORTH BRANCH CORRECTIONAL INST	35.02.08	R	MARIAN	LOGSDON	(301) 729-7037
NORTHEAST MD WASTE DISPOSAL AUTH.	90.00.27	S	CATHERINE	COBLE	410-333-2730
OFFICE OF ADMINISTRATIVE HEARINGS	23.01.11	R	HELEN	MATTHEWS	(410) 229-4116
OFFICE OF THE PEOPLE'S COUNSEL	22.08.00	R	SEVA	DIAKOPARASKEVAS	(410) 767-8150
PATUXENT INSTITUTION	35.04.00	R	ELECTRA	DAVIS	410-799-3400X4524
POLICE & CORRECTIONS TRAINING COMM.	35.07.00	R	TERRY	WEIL	(410) 875-3607
POTOMAC CENTER	32.13.07	R	CAROLYN	HULL	(240) 313-3566
POTOMAC RIVER FISHERIES COMMISSION	90.00.10	S	CLAUDETTE	OKRASINSKI	804-224-7148
PRETRIAL DETENTION SERVICES	35.15.00	R	BETTY	HOPSON	(410) 209-4150
PRINCE GEORGES CO REGISTER OF WILLS	50.02.16	R	JENNIFER	SHEFFLER	(301) 952-3250
PRINCE GEORGES COUNTY CHILD SUPPORT	33.07.00	R	MARTINA	BECK	(301) 316-3349
PRINCE GEORGES COUNTY CIRCUIT COURT	22.01.16	R	JEFF	ALLEN	301-952-4209
PRINCE GEORGE'S COUNTY DSS	33.07.00	R	WANDA	FRANKLIN	(301) 909-7109
PRINCE GEORGE'S COUNTY HEALTH DEPT	32.06.02	R	GREGORY	SMITH	(301) 883-7803

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PROPERTY TAX ASSESSMENT BOARD	24.05.00	R	JULIE	GREENE	(240) 420-5383
PUBLIC BROADCASTING COMM., MARYLAND	36.15.00	R	SUSAN	WOLFINGER	(410) 581-4121
PUBLIC DEFENDER, OFFICE OF THE	22.02.00	R	SAUNDRA	WHEELER	410-767-8497
PUBLIC SAFETY & CORR SVS HDQTRS	35.01.01	R	KAREN	TALIAFERRO	(410) 585-3087
PUBLIC SAFETY & CORR. SVS./DATA DIV	35.01.01	R	BARBARA	MADDEN	410-585-3112
PUBLIC SCHOOL CONSTRUCTION PROGRAM	23.05.03	R	ROBERT C.	CROCETTI	410-767-0612
PUBLIC SERVICE COMMISSION	22.07.00	R	SUSAN	RYNCEWICZ	410-767-6968
QUEEN ANNE'S CO REGISTER OF WILLS	50.02.17	R	DEBORAH	CALLAHAN	410-758-0585
QUEEN ANNE'S COUNTY CIRCUIT COURT	22.01.17	R	BETTY M	COMEGYS	410-758-1773X206
QUEEN ANNE'S COUNTY DSS	33.07.00	R	PEGGY	LANSKROENER	410-758-8014
QUEEN ANNE'S COUNTY HEALTH DEPT	32.06.02	R	KAREN	GRISCOM	(410) 758-0720
REGISTER OF WILLS CECIL COUNTY	50.02.07	R	MELISSA	HELDMYER	410-398-2737
REGISTER OF WILLS HARFORD COUNTY	50.02.12	R	LINDA	BEAVERS	410-879-1940
REGISTER OF WILLS WASHINGTON COUNTY	50.02.21	R	PAULA	COOK	(301) 739-3616
RETIREMENT AGENCY, STATE	26.10.01	R	VANESSA	INGRAM	(410) 625-5662
RICA - BALTIMORE	32.12.05	R	ASHTON	MORGAN	(410) 368-7828
RICA - MONTGOMERY COUNTY	32.12.11	R	DEE DEE	SWARR	301-251-6816
RICA - SOUTHERN MARYLAND	32.12.14	R	LIZ	BENELLI	(301) 372-1831
ROSEWOOD CENTER	32.13.02	R	ERNESTINE	BROWN	410-951-5165
ROXBURY CORRECTIONAL INSTITUTE	35.02.04.	R	DIANE	FLEISCHMAN	(240) 420-3113
SALISBURY UNIVERSITY	36.02.29	R	MARIA	TAWES	(410) 548-4755
SECRETARY OF STATE, OFFICE OF	23.01.06	R	BARBARA	WHEELER	(410) 974-3071
SHA/MATERIAL OFFICE	29.02.01	R	DORA	SIMPKINS	410-321-3030
SOMERSET COUNTY CIRCUIT COURT	22.01.19	R	MELISSA	SMITH	(410) 845-4852
SOMERSET COUNTY DSS	33.07.00	R	PATRICIA	BRODERICK	(410) 677-4336
SOMERSET COUNTY HEALTH DEPARTMENT	32.06.02	R	SANDY	LEATHERBURY	(443) 523-1710
SOMERSET COUNTY REGISTER OF WILLS	50.02.19	R	GARY	MILLER	410-651-1696
SPRING GROVE HOSPITAL CENTER	32.12.09	R	TUESDAY	PROCTOR	(410) 402-7503
SPRINGFIELD HOSPITAL CENTER	32.12.08	R	PAMELA	O'BRYHIM	(410) 970-7028
ST. MARY'S COLLEGE	36.04.00	R	SALLY	DAVIS	(240) 895-4309
ST. MARY'S COUNTY DSS	33.07.00	R	MABLE	BAILEY	(240) 895-7175
ST. MARY'S COUNTY HEALTH DEPARTMENT	32.06.02	R	ROSEMARY	LONGFIELD	301-475-4313
ST. MARY'S COUNTY REGISTER OF WILLS	50.02.18	R	LOIS	DUKE	301-475-5566
STATE BOARD OF ELECTIONS	23.09.01	R	SHARON	PROCTOR	410-269-2859
STATE BOARD OF ELECTIONS	23.09.01	R	SHARON	PROCTOR	410-269-2859
STATE HIGHWAY ADMIN.	29.02.01	R	SH-NAYA	TAYLOR	(410) 545-5578
STATE HIGHWAY ADMIN./DISTRICT #1	29.02.01	R	JANE	BISHOP	410-543-6715
STATE HIGHWAY ADMIN./DISTRICT #2	29.02.01	R	KATHLEEN	WATSON	410-778-3061
STATE HIGHWAY ADMIN./DISTRICT #3	29.02.01	R	SANDY	NELSEN	(301) 513-7328
STATE HIGHWAY ADMIN./DISTRICT #4	29.02.01	R	LESSIE	BURKINS	410-321-2443
STATE HIGHWAY ADMIN./DISTRICT #5	29.02.01	R	KARLA	GROSS	(410) 841-5450
STATE HIGHWAY ADMIN./DISTRICT #6	29.02.01	R	CAROL	HELMSTETTER	(301) 729-8485
STATE HIGHWAY ADMIN./DISTRICT #7	29.02.01	R	TANJA	FULKS	(301) 625-8125
STATE HIGHWAY ADMINISTRATION	29.02.01	R	CECILIA	QUEEN	(410) 787-7633
STATE HIGHWAY ADMINISTRATION	29.02.01	R	SUE	PALMER	(301) 513-7328
STATE PROSECUTOR'S OFFICE	22.04.00	R	DEBORAH	AMIG	410-321-4067
STATE USE INDUSTRIES	35.02.09	R	RENEE	HAMRICK	(410) 540-5465
STATE USE INDUSTRIES	35.02.09	R	KIM	SHIFLETT	(410) 540-5466
SUBSEQUENT INJURY FUND	22.09.00	R	EDGAR	DODD	410-321-2940
TALBOT COUNTY CIRCUIT COURT	22.01.20	R	RUTH	MARTIN	410-822-2611
TALBOT COUNTY DSS	33.07.00	R	PAM	WILKINSON	(410) 820-6694
TALBOT COUNTY HEALTH DEPARTMENT	32.06.02	R	BARBARA	JARRRELL	410-819-5669
TALBOT COUNTY REGISTER OF WILLS	50.02.20	R	EDNA	BLUE	410-770-6700
TAX COURT, MARYLAND	22.05.00	R	JOHN	HEARN	(410) 767-4824
THE ARC OF ANNE ARUNDEL COUNTY, INC	95.00.28	S	LAURIE	SCIBLE	(410) 990-1906
THOMAS B. FINAN HOSPITAL CENTER	32.12.04	R	PAULA	BRODE	301-777-2236
TOWN OF CHEVY CHASE	95.00.25	S	ANDREA	SILVERSTONE	(301) 654-7144
TOWN OF DENTON	90.00.18	S	SYLVIA	WOOD	410-479-2050
TOWN OF KENSINGTON	95.00.22	S	SUSAN	ENGELS	(301) 949-2424
TOWN OF NORTH BEACH	90.00.13	S	BEVERLEY	MCINNIS	(301) 855-6681
TOWN OF QUEENSTOWN	95.00.12	S	AMY	MOORE	410-827-7646
TOWSON UNIVERSITY	36.02.24	R	DAVE	CURTIS	410-704-6018
TREASURER'S OFFICE, STATE	24.02.01	R	SHELLY	REID	410-260-7078
TRI-COUNTY FOR SOUTHERN MD	95.00.27	S	LOIS	JOHNSON	(301) 870-2520
UNINSURED EMPLOYERS' FUND, MD	22.10.00	R	HOLLY	ISAACS	410-321-4136
UNIV MD-CTR FOR ENVIR. SCIENCES	36.02.34	U	SUZANNE	LUERS	(410) 228-9250
UNIV OF MARYLAND MEDICAL SYSTEM	90.00.15	S	SHARON	SCHILLINGER	(410) 328-7492
UNIV OF MD UNIVERSITY COLLEGE	90.00.07	S	J	SUH	

* If you do not see your agency listed, please contact your Benefits Coordinator for your agency code.

STATE OF MARYLAND AGENCY REFERENCE SHEET APRIL 2006

AGENCY	AGENCY CODE	PAYROLL CODE	BENEFIT COORDINATOR		TELEPHONE
UNIV SYSTEMS OF MARYLAND	36.02.36	U	MARTHA	WARREN	(301) 445-1970
UNIV SYSTEMS OF MD	36.02.36	U	ROSARIO	VAN DAALEN	(301) 445-1969
UNIV. OF MARYLAND - COLLEGE PARK	36.02.22	R	STACY	SIMS	301-405-5654
UNIV. OF MD - BALTIMORE COUNTY	36.02.00	U	COURTNEY	ALLEN	(410) 455-3648
UNIV. OF MD - BIOTECHNOLOGY INST.	36.02.35	U	DELORES	FINDLEY	410 385-6338
UNIV. OF MD - UNIVERSITY COLLEGE	36.02.30	U	RASHEL	FREEMAN	(240) 684-5555
UNIV. OF MD - UNIVERSITY COLLEGE	90.00.14	S	EMI	IKEDA	
UNIVERSITY OF BALTIMORE	36.02.28	R	JUNE	HINDLE	410-837-5410
UNIVERSITY OF MD - EASTERN SHORE	36.02.25	U	MARTHA	SMITH	410-651-6403
UNIVERSITY OF MD, BALTIMORE	36.02.21	U	BEVERLY	JACKSON	(410) 706-2616
UPPER SHORE COMMUNITY HEALTH CENTER	32.12.12	R	SUSAN	STRAYER	(410) 778-6800
WALTER P CARTER CENTER	32.12.03	R	MICHAEL	COLEMAN	(410) 209-6072
WASH CO HUMAN DEVELOPMENT COUNCIL	95.00.23	S	MARY	CUNNINGHAM	(301) 791-5421
WASHINGTON CO BOARD OF LICENSE COMM	95.00.14	S	RICK	HEMPILL	301 797-4591
WASHINGTON COUNTY CIRCUIT COURT	22.01.21	R	RICK	HEMPHILL	301-733-8660
WASHINGTON COUNTY DSS	33.07.00	R	BRUCE	MASSEY	(240) 420-2639
WASHINGTON COUNTY HEALTH DEPARTMENT	32.06.02	R	CAROL	KANE	(240) 313-3489
WAXTER CHILDREN'S CENTER	40.02.12	R	SHADENA	HARLEY	410-792-7416
WESTERN CORRECTIONAL INSTITUTION	35.02.08	R	CINDY	WATKINS	(301) 729-7035
WESTERN MARYLAND HOSPTIAL CENTER	32.09.03	R	DEBORAH	SANDERS	(301) 791-4498
WESTERN MD AREA HEALTH EDUC. CENTER	90.00.22	S	SHARON	DONAHOE	301-777-9150
WHITSITT CENTER	32.06.02	R	TERRY	MILASH	(410) 778-6404
WICOMICO COUNTY CIRCUIT COURT	22.01.22	R	WENDY	RESTEIN	410-543-6551 X208
WICOMICO COUNTY DSS	33.07.00	R	PAT	RICHARDSON	(410) 543-6813
WICOMICO COUNTY HEALTH DEPARTMENT	32.06.02	R	PAM	THOMPSON	(410) 543-6932
WICOMICO COUNTY REGISTER OF WILLS	50.02.22	R	BONNIE	MUELLER	410-543-6635
WORCESTER COUNTY CIRCUIT COURT	22.01.23	R	FAITH	MUMFORD	(410) 632-5500
WORCESTER COUNTY DSS	33.07.00	R	SHANNON	CHAPMAN	(410) 677-6873
WORCESTER COUNTY HEALTH DEPARTMENT	32.06.02	R	SHARON	BEYMA	410-632-1100
WORCESTER COUNTY REGISTER OF WILLS	50.02.23	R	TAMARA	WHITE	410-632-1529

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